IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

SOUMA DIAGNOSTICS, INC,

Plaintiff,

v.

PRINCIPAL FINANCIAL GROUP,

Defendant.

Case No. _____

_____
U. S. District Court Judge

DEFENDANT'S NOTICE OF REMOVAL OF CAUSE

Defendant, Principal Life Insurance Company, incorrectly sued as Principal Financial Group ("Principal Life"), pursuant to 28 U.S.C. §§1441, 1446 and the Local Rules of the United States District Court for the Northern District of Illinois, notifies this Honorable Court that the above-entitled cause has been removed from the Circuit Court of Cook County, Illinois, and in support of said notice states as follows:

BACKGROUND

Plaintiff, Souma Diagnostics, Inc. ("Plaintiff"), commenced this action by filing and then personally serving a copy of the Summons and Complaint on Principal on July 23, 2008. (A true and correct copy of the Complaint is attached hereto as **Exhibit 1.**) The Complaint sounds in claims for declaratory judgment (Count I), breach of contract (Count II), fraudulent misrepresentation (Count III), fraudulent concealment (Count IV), and consumer fraud (Count V), arising out of Plaintiff's alleged overpayment of premiums for group insurance coverage underwritten by Principal pursuant to the terms of a group insurance policy. (Ex. 1 at Ex. A.) In its Complaint, Plaintiff is seeking payment of $108,011.00 in actual and compensatory damages and $500,000.00 in punitive damages plus attorneys' fees and costs. The Complaint specifically

sets forth the amount of the relief sought and is removable on its face. Principal Life denies that it is liable to Plaintiff for any of the relief sought in the Complaint.

GROUNDS FOR REMOVAL

A. This Court Has Diversity Jurisdiction Over This Matter.

A state court action may be removed to a Unites States District Court where such District Court has original jurisdiction. 28 U.S.C. §1441. In the present matter, original jurisdiction exists pursuant to 28 U.S.C. §1132, which provides in pertinent part:

> ***
>
> (a) The district courts shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of $75,000, exclusive of interest and costs, and is between -
> ***
>
> (1) Citizens of different States[.]

28 U.S.C. §1132(a)(1)

1. The Amount in Controversy Exceeds $75,000

The Complaint filed in this matter is clear on its face that Plaintiff seeks in excess of $75,000 in damages exclusive of interest and costs, as it seeks payment of $73,011.00 in reimbursement for overpaid premiums, $35,000.00 in reimbursement for paid medical expenses and $500,000.00 in punitive damages. (Ex. 1). As such, Plaintiff seeks an award of $608,011.00 in compensatory and punitive damages and the amount in controversy exceeds $75,000.00

2. This Action is between Citizens of Different States.

Plaintiff, a corporation, "shall be deemed to be a citizen of any State by which it has been incorporated and of the State where it has its principal place of business." 28 U.S.C. §1132(c)(1). Here, Plaintiff filed its complaint in Cook County, Illinois and alleges that its principal place of business is in Cook County, Illinois. (Ex. 1 at ¶2) According to the Illinois

Secretary of State information, Plaintiff is further incorporated under the laws of the State of Illinois (Ex. 2) and as such, for diversity purposes, is a citizen of the State of Illinois. Principal Life is a corporation organized under the laws of the State of Iowa with its principal place of business in Des Moines, Iowa.[1] (Ex. 1 at ¶3).

Accordingly, complete diversity between the parties existed at the time Plaintiff filed her Complaint and diversity jurisdiction exists now.

CONCLUSION

For all of the above reasons, this Court has original jurisdiction over this action under 28 U.S.C. §1332. Principal Life is entitled to remove this action to this Court pursuant to 28 U.S.C. §§1332, and 1441. In compliance with 28 U.S.C. §1446(b), this Notice of Removal is filed with this Court within thirty (30) days after receipt of and service with the Complaint.

WHEREFORE, Defendant Principal Life Insurance Company, incorrectly sued as Principal Financial Group, notifies that this cause has been removed from the Circuit Court of Cook County, Illinois, to the United States District Court for the Northern District of Illinois, Eastern Division, pursuant to the provisions of 28 U.S.C. §1446 and the Local Rules of the United States District Court for the Northern District of Illinois.

Respectfully Submitted,

PRINCIPAL LIFE INSURANCE COMOANY, incorrectly sued as PRINCIPAL FINANCIAL GROUP, Defendant

By: */s/ Edna S. Bailey*
One of its attorneys

Rebecca M. Rothmann
Edna S. Bailey
WILSON, ELSER, MOSKOWITZ,

[1] Principal Financial Group, Inc., which Plaintiff erroneously sues, is incorporated under the laws of the State of Delaware, with its principal place of business in Des Moines, Iowa.

EDELMAN & DICKER LLP
120 North LaSalle Street, Suite 2600
Chicago, IL 60602
(312) 704-0550
(312) 704-1522
edna.bailey@wilsonelser.com

CERTIFICATE OF SERVICE

The undersigned, an attorney, hereby certifies that on August 20, 2008, a copy of the foregoing was served by operation of the Court's electronic filing systems upon the following:

Attorney for Plaintiff
John L. Malevitis
Spartacus Law, P.C.
218 North Jefferson Street,
Suite 400
Chicago, Illinois 60661
(312) 258-1100

Parties may access this filing through the Court's system.

/s/ Edna S. Bailey
Edna S. Bailey

08CV4728
JUDGE GUZMAN
MAGISTRATE JUDGE SCHENKIER

PH

IN THE CIRCUIT COURT OF COOK COUNTY , ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

SOUMA DIAGNOSTIC, LTD.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	NO.: 08 CH
	)	
PRINCIPAL FINANCIAL GROUP,	)	
Defendant.	)	

FILED-A
2008 JUL -3 AM 10: 2
CLERK OF THE CIRCUIT COURT
COOK COUNTY, IL
CHANCERY DIV.
DOROTHY BROWN

08CH24027

CLERK OF THE CIRCUIT COURT - COOK COUNTY
ATTY: 13049 924 LIAKAS
CASE NO: 2008CH24027
COURT DATE: 0/0/70000 12:00AM
CASE TOTAL: $319.00
Case Filing Fee 6
Document Storage
CALENDAR: 11
$240.00
$15.00
$25.00
$1.00
$25.00
$319.00
$0.00

PLAINTIFF'S VERIFIED COMPLAINT

NOW COMES the Plaintiff, Souma Diagnostic, Ltd., *(hereinafter referred to as "Souma")* by and through its attorney, John L. Malevitis, Esq. of SPARTACUS LAW, P.C., and for its Verified Complaint complaining of Defendant Principal Financial Group, (*hereinafter referred to as "Principal"*) states as follows:

1. In this action, Plaintiff seek: (I) a declaration that it at all relevant times was covered by a policy of insurance issued by the Defendant which specifically included insurance coverage for Ms. Asthma Sabbagha from 1999-2007 and further that it is entitled to a return of all insurance premium money that it unknowingly overpaid to the Defendant over the course of several years. During the period from 1999-2007 the Plaintiff was overcharged by the Defendant, and the Defendant with full knowledge of material misrepresentations to the Plaintiff continued to collect improper premium amounts from the Plaintiff. and each of them, to the Plaintiffs; and actual and punitive damages.

PARTIES AND VENUE

2. The Plaintiff is a company with its principal place of business located in Chicago, Cook

EXHIBIT
tabbies
1

County, Illinois.

3. Defendant Principal is an Iowa corporation, and at all relevant times hereto, duly authorized to do business in the State of Illinois.

4. The transaction out of which the cause of action set forth herein arose, or some part thereof, occurred in Cook County, Illinois.

5. On or about April 15, 1999 the Plaintiff entered into a group insurance policy with Principal which afforded insurance coverage to the Plaintiff and its employees, spouses and dependents. (A copy of the Group Booklet-Certificate for Members is attached hereto and incorporated herein as Exhibit "A").

6. Beginning on August 15, 1999 and continuing to August 14, 2000, Plaintiff paid Defendant the sum of $544.85 per month for the premium relating to group member Ms. Asma Sabbagha. In fact, but unknown to the Plaintiff, the correct premium for this month period should have been $296.23. The Plaintiff for this month period overpaid the Defendant the sum of $248.62.

7. This course of conduct continued for the next period of insurance coverage from August 15, 2000 to August 14, 2001. In said period of insurance coverage the Plaintiff paid Defendant the sum of $749.99 per month for the premium relating to insurance coverage for group member Ms. Asma Sabbagha. In fact, but unknown to the Plaintiff, the correct premium for this moth period should have been $244.13. The Plaintiff for this month period overpaid the Defendant the sum of $505.86 per month for the period of one (1) year.

8. Thereafter on August 15, 2001 and continuing until August 14, 2002, Plaintiff paid Defendant the sum of $739.16 per month for the premium relating to insurance coverage for

group member Ms. Asma Sabbagha. In fact, but unknown to the Plaintiff, the correct premium for this month period should have been $240.17 per month. The Plaintiff for this month period overpaid the Defendant the sum of $498.99 per month for the period of one (1) year.

9. This course of over billing and overcharging conduct by the Defendant continued for the following years and in the following amounts: From August 15, 2002 to August 14, 2003, Plaintiff paid the monthly insurance premium in the amount of $941.42 to the Defendant, when in fact the correct premium amount was $297.73, resulting in an overpayment of premiums by the Plaintiff to the Defendant isn the amount of $643.69 per month for a period of one (1) year; From August 15, 2003 until August 14, 2004, Plaintiff paid the monthly insurance premium to the Defendant in the amount of $1,087.64, when in fact the correct premium amount was $340.06, resulting in an overpayment of premiums by the Plaintiff to the Defendant in the amount of $747.58 per month for a period of one (1) year; From August 15, 2004 to August 14, 2005, Plaintiff paid the monthly insurance premium in the amount of $1,230.46 to the Defendant, when in fact the correct premium amount was $382.77, resulting in an overpayment of premiums by the Plaintiff to the Defendant in the amount of $847.69 per month for a period of one (1) year; From August 15, 2005 to August 14, 2006, Plaintiff paid the monthly insurance premium in the amount of $1,675.09 to the Defendant, when in fact the correct premium amount was $477.09, resulting in an overpayment of premium by the Plaintiff to the Defendant in the amount of $1,198.00 per month for a period of one (1) year; and from August 15, 2006 to August 14, 2007, Plaintiff paid the monthly insurance premium to the Defendant in the amount of

$1,929.37 to the Defendant, when in fact the correct premium amount was $535.55, resulting in an overpayment of premiums by the Plaintiff to the Defendant in the amount of $1,393.82. The aforesaid overpayments of insurance premiums by the Plaintiff to the Defendant totaled the sum of $73,011.00.

10. That prior to1999, the Plaintiff was never advised by the Defendant that it was being overcharged and/or that the Plaintiff was overpaying insurance premium amounts, although the Defendant had full knowledge of these facts and insurance premium amounts billed to the Plaintiff.

11. Each and every month from 1999 to and including 2007 the Defendant would issue an insurance premium bill to the Plaintiff in the amounts as aforesaid, and the Plaintiff would promptly pay said amount as becoming due.

12. Additionally, beginning in June of 2006 and continuing to and including August of 2006, Ms. Asma Sabbagha was provided neurosurgical treatment at Northwestern Memorial Hospital in Chicago, Illinois for which she received medical bills in the amount of $35,000.00. When the Plaintiff presented the medical bills to the Defendant for payment, the Defendant refused to pay the medical bills despite the Plaintiff's having insurance coverage for said medical bills and being previously advised by the Defendant in 2006 that the neurosurgical care and treatment was covered under the Plaintiff's insurance policy.

13. The Defendant has refused to return the overpayment of insurance premium amounts to the Plaintiff, and has refused to repay the amount of $35,000.00 in which the Plaintiff paid out of pocket for the aforesaid medical bills incurred by group memeber Asma

Sabbagha.

14. The Plaintiff, prior to August 15, 1999 and continuing to August 14, 2007 have not defaulted or caused any event of default pursuant to the terms of the Insurance Contract, and at all relevant times, have consistently paid the insurance premiums when becoming due.

15. The Plaintiff has been damaged by Defendant's breach of contract, namely the Defendant's refusal to return all of the overpayment amounts made by the Plaintiff to the Defendant and the out of pocket amount of $35,000.00 paid by the Plaintiff for the medical bills of group member Asma Sabbagha.

16. Accordingly, based upon all of the foregoing, there is an actual controversy between the parties.

WHEREFORE the Plaintiff respectfully requests that this Honorable Court determine and adjudicate the rights and responsibilities of the parties to this cation, and specifically request the following relief:

A. That this Honorable Court find and declare that the Court having determined the rights of the Plaintiff to the damages incurred and award the Plaintiff the immediate return of the overpayment money for insurance premiums paid heretofore in the amount of $73,011.00, the out of pocket medical bills paid by the Plaintiff in the amount of $35,000.00, attorney's fees, and the costs of this action.

COUNT I-DECLARATORY JUDGMENT

17. The Plaintiff realleges paragraphs 1-16 above as though fully set forth herein as paragraph 17.

18. Section 2-701 (a) of the Illinois Code of Civil Procedure, 735 ILCS 5/2-701, authorizes the

Court to make declaratory judgments as follows: The Court may, in cases of actual controversy, make binding declarations of rights, having the force of final judgment, whether or not any consequential relief is or could be claimed, including the determination, at the instance of anyone interested in the controversy, of the construction...Of any...contract or other written instruments, and a declaration of the rights of the parties interested. 735 ILCS 5/2-701 (a).

19. As set forth above, there is an actual controversy between the parties as to the Plaintiff's rights under the Group Insurance Contract.

WHEREFORE the Plaintiff respectfully requests that this Court determine and adjudicate the rights and responsibilities of the parties to this action, and specifically request the following relief:

A. That this Honorable Court find and declare that the Court having determined the rights of the Plaintiff to the damages incurred and award the Plaintiffs the immediate return of the overpayment money in insurance premiums heretofore, attorney's fees, and the costs of this action.

COUNT II-BREACH OF CONTRACT

20. Plaintiff realleges paragraphs 1-19 above as though fully set forth herein as paragraph 20.

21. The parties entered into a written contract dated August 15, 1999 and continuing until August 14, 2007 whereby the Defendant agreed to provide insurance coverage to the Plaintiff, its employees, spouses and dependants for which the Plaintiff would pay a monthly insurance premium to the Defendant. (See Exhibit "A").

22. In addition to the aforesaid, in June of 2006 and continuing to and including August of 2006, Ms. Asma Sabbagha received neurosurgical treated at Northwestern Memorial Hospital in

Chicago, Illinois for which she was billed $35,000.00. When the Plaintiff presented the hospital and medical bills for payment to the Defendant, the Defendant refused to pay said bills. Plaintiff was therefore required to pay the medical bills out of pocket in the amount of $35,000.00 despite having insurance coverage for these bills.

23. The Plaintiff made demand of the Defendant for the return of its overpayment money in insurance premiums, and the Defendant, in breach of the written contract, has refused to return the both the overpayment amounts and the out of pocket medical bills paid by the Plaintiff for group member Asma Sabbagha.

WHEREFORE the Plaintiff requests that this Court enter an Order in their favor and against the Defendant in a sum in excess of $108,011.00.

COUNT III-FRAUDULENT MISREPRESENTATION

24. Plaintiff realleges paragraphs 1-23 above as though fully set forth herein as paragraph 24.

25. Defendant, beginning in August of 1999 and continuing through and including August of 2007 represented to the Plaintiff the amount of its monthly insurance premiums and demanded payment by the Plaintiff to the Defendant each and every month during this period.

26. Defendant knew this representation to be false since it had actual knowledge of the insurance premiums and billing of said insurance premiums to the Plaintiff.

27. That despite this actual knowledge of the correct insurance premiums that it should have billed the Plaintiff on a monthly basis, the Defendant misrepresented the insurance premium amounts to the Plaintiff from August of 1999 to and including August of 2007.

28. The Defendant intentionally failed to disclose to the Plaintiff during this period as aforesaid

the true and correct insurance premiums in order to achieve financial gain and profit.

29. That despite Defendant's's actual knowledge of these material facts, Defendant intentionally failed to disclose to the Plaintiff the true and correct insurance premium amounts to cause the Plaintiff to overpay its insurance premiums. Had the Plaintiff known of this overcharging tact by the Defendant the Plaintiff would have discontinued its overpayment to the Defendant. The Defendant further failed to pay the hospital bills of Asma Sabbagha in the amount of $35,000.00 when it previously advised the Plaintiff in 2006 that the medical care and treatment of Asma Sabbagha was covered under the Plaintiff's insurance with the Defendant.

30. The Plaintiff at all relevant times as aforesaid detrimentally relied upon the material representations made by the Defendant from August 1999 to and including August 2007, which has caused the Plaintiff to sustain substantial damages in excess of $105,000.00.

WHEREFORE the Plaintiff respectfully requests that this Court enter judgment in its favor and against the Defendant's in the amount of $108,011.00 plus court cost, attorney's fees, and enter an award in favor of the Plaintiff and against the Defendant in the amount of $500,000.00 for punitive damages, and for all other relief as this Court deems just and reasonable.

COUNT IV-FRAUDULENT CONCEALMENT

31. Plaintiff realleges paragraphs 1-30 above as though fully set for th herein as paragraph 30.

32. That Defendant actively concealed the true and correct amount of insurance premiums from the Plaintiff in order to achieve financial gain and profit, and further failed to pay the medical bills of Asma Sabbagha in the amount of $35,000.00 despite the Plaintiff having insurance coverage by the Defendant for said medical care and treatment.

33. That the Plaintiff detrimentally relied on Defendant's's monthly insurance premium bills and promptly paid said insurance premiums as becoming due from August 1999 to and including August 2007, and further paid out of the pocket the sum of $35,000.00 for the medical bills of Asma Sabbagha following the Defendant's refusal to pay said medical bills.

34. That as a result of Plaintiff's reliance on Defendant's fraudulent actions and active concealment of the true and correct insurance premiums, and based upon the Defendant's refusal to pay the medical bills of Asma Sabbagha in the amount of $35,000.00, the Plaintiff has sustained substantial damages in excess of $108,011.00.

WHEREFORE Plaintiff respectfully requests that this Court enter an Order in its favor and against the Defendant in the amount of $108,011.00 plus court costs, attorney's fees and enter an award in its favor and against the Defendant in the amount of $500,000.00 for punitive damages and for all other relief as this Court deems just and reasonable.

COUNT V-VIOLATION OF THE CONSUMER FRAUD AND DECEPTIVE PRACTICE ACT

35. Plaintiff realleges paragraphs 1-34 above as though fully set forth herein as paragraph 35.

36. Illinois has enacted The Consumer Fraud and Deceptive Practices Act, codified at 815 ILCS 505/1 et seq. (hereinafter the "Act") which in relevant part provides: **"Unfair methods of competition and unfair or deceptive acts or practice, including but not limited to the use or employment of any deceptive, fraud, false pretense, false promise, misrepresentation or the concealment, suppression or omission of any material fact, with intent that others rely upon the concealment, suppression, omission of such material fact, or the use of employment of any practice described in Section 2 of the**

Uniform Deceptive Trade Practice Act," approved August 5, 1965 [815 ILCS 510/2], in the course of any trade or commerce are hereby declared unlawful whether any person has in fact been misled, deceived or damages thereby, " 815 ILCS 505/2 (1995) (emphasis added).

37. With respect to the recovery of damages, the Act, in relevant part provides: (a) Any person who suffers damages as a result of a violation of the Act committed by any person may bring an action against such person. The Court, in its discretion, may award actual damages or any other relief which the Court deems proper. Proof of a public injury a pattern or an effect on consumers generally shall not be required. (B). Except as provided in subsection (f) of this Section, in any action brought by a person under this Section, the Court may grant injunctive relief where appropriate and may award punitive damages and attorney's fees.

38. Souma, the Plaintiff herein is a "person" who may bring an action for violation of the Act.

39. Principal, the Defendant herein, is a "person" against whom an action may be brought for violation of the Act.

40. As set forth above, Defendant intentionally issued false, misleading, deceptive and inaccurate monthly insurance premium bills to the Plaintiff beginning in August 1999 and continuing to and including August of 2007. Furthermore, in 2006 the Defendant advised the Plaintiff that the neurosurgical procedure needed by group member Asma Sabbagha would be covered under the Plaintiff's insurance policy with the Defendant.

41. The Defendant violated the Illinois Consumer Fraud and Deceptive Business Practices Act through the following false, unfair, fraudulent and deceptive practices, misstatements, omissions or failure to disclose the following material facts concerning the insurance

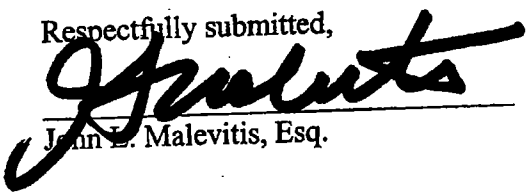
premiums: The Defendant from 1999 to 2007 systematically sent to the Plaintiff monthly insurance premium bills which contained overstated and overcharged premium amounts with full knowledge that said premiums were inaccurate, overinflated and misstated in order to achieve financial gain and profit. Additionally, the Defendant refused to pay the medical bills incurred by Asma Sabbagha for neurosurgical treatment received from June 2006 to August 2006 in the amount of $35,000.00 despite the Plaintiff having insurance coverage with the Defendant for said medical care and treatment.

42. As a direct and proximate result of the above described violation of the Consumer Fraud Act by the Defendant, the Plaintiff has sustained substantial pecuniary losses in excess of $108,011.00, attorney's fees and court costs.

43. As provided under Section 505/10 (a) of the Act, the Plaintiff requests that this Court also award, in addition to the other relief provided under the Act, reasonable attorney's fees, actual damages, punitive damages, and the costs of this action.

WHEREFORE Plaintiff respectfully requests that this Court enter judgment in its favor and against the Defendant's, for actual damages in the amount of $108,011.00, punitive damages in the amount of $500,000.00, attorney's fees, costs of this action, and any other relief as the Court may deem just and reasonable.

Respectfully submitted,



John E. Malevitis, Esq.

SPARTACUS LAW, P.C.
218 N. Jefferson Street
Suite 400
Chicago, Illinois 60661
(312) 258-1100
Atty. No.: 13049

Verification

I, Rudy Sabbagha, President of Souma Diagnostic, Ltd., certify that I have read the foregoing Complaint, and to the best of my knowledge, information and belief formed after reasonable inquiry, the facts alleged therein are true and accurate, except as to those matters based upon information and belief.

Rudy Sabbagha, President of Souma Diagnostic, Ltd.

Subscribed to and Sworn before me this

16th day of June, 2008

Notary Public

OFFICIAL SEAL
ARCHER WOGGON
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/20/11

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SOUM
602
08/15/2005

Principal® Financial Group

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF

SOUMA DIAGNOSTIC LTD

MEMBERS INSIDE PPO SERVICE AREA
Group Medical Preferred Provider Organization (PPO) Insurance

Print Date: 09/13/2005

Your insurance has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

Member rights and benefits are determined by the provisions of the Group Policy. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

The effective date of your insurance is as shown on your enrollment card.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. If you have any questions about this new booklet, please contact your employer. In the event of future changes to your coverage, you will be provided with a new booklet-certificate or a booklet-certificate rider.

If you have an electronic booklet, paper copies of this booklet-certificate are also available. Please contact your employer if you would like to request a paper copy.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

The group insurance policy and your coverage under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

YOUR MEDICAL BENEFITS MAY BE REDUCED IF THE UTILIZATION MANAGEMENT REQUIREMENTS DESCRIBED IN THIS BOOKLET ARE NOT FOLLOWED. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE TOLL-FREE NUMBER SHOWN ON YOUR ID CARD ON ANY BUSINESS DAY OR SEE YOUR EMPLOYER FOR THE TOLL-FREE NUMBER.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

The insurance provided in this booklet is subject to the laws of the state of ILLINOIS.

PRINCIPAL LIFE INSURANCE COMPANY
Des Moines, IA 50392-0001

YOUR ROLE IN CONTROLLING HEALTH CARE COSTS

Making choices about your health can sometimes be difficult. When you seek health care, take the same approach you use for buying anything else. Ask questions. Make sure you get the most appropriate care for your condition. Use the following guidelines to help you be a wise health care consumer:

Practice Good Health Habits. Staying healthy is the best way to control your medical costs. Eat a balanced diet, exercise regularly, and get enough sleep. Learn how to handle stress. Stop smoking and avoid excessive use of alcohol.

See your Doctor Early. Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

Make Sure You Need Surgery. If a second opinion program is included in your coverage, get one if you're unsure about the surgery you face. If you need surgery, ask about same day surgery. Many procedures can be performed safely without a Hospital stay. You have these surgeries as an outpatient or at a place other than a Hospital and go home the same day.

Use Outpatient Services for X-ray or Laboratory Tests. Outpatient preadmission and diagnostic tests can save costly room and board charges.

Compare Prescription Drug Prices. Discuss the use of generic drugs with your doctor or pharmacist. Generic drugs are often cheaper than brand name drugs for the same quality.

Consider Hospital Stay Alternatives. Home Health Care, Skilled Nursing Facilities, and Hospice Care services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

Review Medical Bills Carefully. Make sure you understand all charges and receive bills only for services you receive. Keep your medical records up-to-date.

Talk to Your Doctor. Discuss the need for treatment with your doctor. It is your body. To make wise health care decisions, you must understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's health care costs, your doctor will understand your concern about your medical expenses.

Be a wise health care consumer. Review your benefits carefully so you can make informed health care decisions. You can help control health care costs while getting the most your health care insurance has to offer.

BENEFIT ADVICE

WE WANT TO HELP YOU BE A WISE HEALTH CARE CONSUMER. PLEASE GIVE US A CALL IF YOU HAVE ANY QUESTIONS ABOUT YOUR MEDICAL INSURANCE.

1-800-247-4695

YOU MAY REFER TO THE CLAIM PROCEDURES SECTION OF THIS BOOKLET FOR MORE DETAILED INFORMATION.

TABLE OF CONTENTS

SUMMARY OF BENEFITS
(revised effective August 15, 2005)

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

If you or one of your Dependents are sick or injured, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

Class	Scheduled Benefit
All Members and their Dependents	Comprehensive Medical, Prescription Drugs and Mail Service Prescription Drugs

PREFERRED PROVIDER ORGANIZATION (PPO)

Your employer participates in a Preferred Provider Organization (PPO) network established and administered by the PPO identified on your ID card.

As you may know, Preferred Provider Organization networks are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for the employees and their Dependents of participating employers.

It is expected that your employer's participation in the PPO will result in significant savings of funds needed to maintain your insurance. These savings are to be passed on to you in the form of higher benefits payable for services received by you or a Dependent from Preferred Providers.

Please note that your employer's participation in the PPO network does not mean that your choice of provider will be restricted. You may still seek needed medical care from any Hospital, Physician, or other provider you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of this insurance if We or the PPO terminate the arrangement.

We also have the right to identify different Preferred Provider Organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

A current listing of the participating Hospitals, Physicians, and other providers is available through an on-line Preferred Provider directory. By accessing the Principal Life Insurance Company website www.principal.com, you can review Preferred Provider directories for your PPO Network. Click on "Provider Directory," then "Search for a Medical Provider," then you can continue to follow the prompts to find your PPO Network. If you do not have internet access, you can request a paper copy of the provider directory for your PPO network from (800) 554-3392 for medical providers. Whether using the internet or a paper directory, we recommend that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm PPO participation with your provider when making your appointment.

MEDICAL CARE COVERED CHARGES

Benefits payable will be based on four Categories of medical care services as described below.

See page GH 411 A for a full description of Covered Charges.

BENEFITS PAYABLE

Benefits will be payable during a calendar year as shown below, and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization.

Service	PPO Providers	Non-PPO Providers
Hospital Services		
Inpatient Hospital Services		
Coinsurance	90%	70%
Deductible	$250*	$250*
Copay	None	$500 per admission, in addition to the calendar year Deductible shown above.

Hospital Services Covered Charges for Birthing Center Services, Ambulatory Surgery Center Services, and freestanding dialysis center services will be subject to the applicable calendar year Deductible Amount.

Outpatient Hospital Services (other than outpatient, clinic or office-based surgery)		
Coinsurance	90%	70%
Deductible	$250*	$250*
Copay	None	None
Outpatient, clinic or office-based Surgery at a Hospital		
Coinsurance	90%	70%
Deductible	$250*	$250*
Copay	None	None
Emergency Room Visits		
Coinsurance	90%	70%
Copay	None	$100 per-visit, in addition to the calendar year Deductible. (Waived if admitted.)
Deductible	$250*	$250*
Physician Hospital Services		
Physician Hospital Services (including surgery and Physician Visits)		
Coinsurance	90%	70%
Copay	None	None

Deductible	$250*	$250*

Physician Office or Clinic Services

Services at a Primary Care Physician's office or clinic (other than MRIs, CATS, SPECTs, PETs and other similar imaging tests)

"Primary Care Physician" means a Physician who is a family or general practitioner, internist, obstetrician/gynecologist or pediatrician.

Coinsurance	100%	70%
Copay	$10 per visit.	None
Deductible	None	$250*

Services at a Specialty Provider's office or clinic (other than MRIs, CATS, SPECTs, PETs and other similar imaging tests)

"Specialty Provider" means any Physician other than a Primary Care Physician who is classed as a specialist by the American Boards of Medical Specialties; or who is designated by the Group Policy as a Specialty Provider.

Coinsurance	100%	70%
Copay	$10 per visit.	None
Deductible	None	$250*

All Other Covered Services

Ambulance Services

Coinsurance	90%	90%
Copay	None	None
Deductible	$250*	$250*

Other Medical Services (including MRIs, CATs, SPECTs, PETs and other similar imaging tests)

Coinsurance	90%	70%
Copay	None	None
Deductible	$250*	$250*

Services provided by a Non-PPO anesthesiologist, radiologist, and pathologist

For services provided by a Non-PPO anesthesiologist, radiologist, and pathologist, benefits will be payable at the PPO coinsurance level when such services are provided at a PPO Hospital (inpatient, outpatient, and emergency room) or a licensed freestanding surgical center.

COPAY AMOUNTS

Copays cannot be used to satisfy the individual or family calendar year Deductible maximums and will continue to apply after the calendar year Deductible and the Out-of-Pocket Expense limits have been satisfied. This applies to:

- the Hospital Services Hospital per admission Copay amount; and
- the Physician Office or Clinic Services per-visit Copay amount; and
- the emergency room per-visit Copay amount.

In addition, the Copay provision does not apply to charges incurred for MRIs, CATs, SPECTs, PETs and other similar imagining tests. These charges are subject to the calendar year Deductible.

DEDUCTIBLE AMOUNTS

*You pay a single $250 per individual Deductible each calendar year (or $750 per family, but not counting more than $250 for any one person). After you satisfy the Deductible, We will pay Covered Charges at the rate of payment shown above.

OUT-OF-POCKET EXPENSE MAXIMUMS (for each calendar year):

	PPO Providers	Non-PPO Providers
Per Person	$1,000	$2,000
Per Family	$2,000	$4,000

Covered Charges used to satisfy the Out-of-Pocket Expense limits that apply when care is received from a PPO provider will be used to satisfy the Out-of-Pocket Expense limits that apply when care is received from a Non-PPO Provider and vice versa.

If the amount you pay for Covered Charges in any one calendar year reaches the Out-of-Pocket Expense Maximum shown above, We will pay 100% of additional Covered Charges (except as described above under "Copay Amounts").

The following charges will not count toward satisfaction of the Out-of-Pocket Expense Maximums:

- Covered Charges for which no benefits are payable because of the Utilization Management Requirements penalty; or
- The Hospital Services Hospital per admission Copay amount; or
- The Physician Office or Clinic Services per-visit Copay amount; or
- The emergency room per-visit Copay amount; or
- Covered Charges for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services, except such services for Inpatient Hospital Confinement and Partial Hospitalization or Day Treatment Services for Alcohol or Drug Abuse Treatment Services as described in GH 411 B.

For Physician Office or Clinic Services Covered Charges: The coinsurance amount you pay in excess of the per-visit Copay amount will be counted toward satisfaction of the Out-of-Pocket Expense Maximum shown, but will not be counted toward satisfaction of the calendar year Deductible.

The following exceptions apply to the Benefits Payable provisions described above:

- For medical care received from Non-PPO Providers: Hospital Inpatient Confinement Charges, benefits payable will be reduced by 25% (but not more than $2,000 per individual each calendar year) unless the Utilization Management Requirements are satisfied. **See page GH 407 CC for a complete description of the Utilization Management Program.**

- For Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. **See page GH 411 B for a complete description of the benefits payable for these services.**
- For payment conditions applicable to Transplant Services, see GH 411 C.
- For payment conditions applicable to emergency room treatment, see GH 411 H.
- For payment conditions applicable to Rehabilitative Services, see GH 411 F.
- For payment conditions applicable to Wellness Services, see GH 411 E.
- For payment conditions applicable to outpatient x-ray services, see page GH 411 G.
- For payment conditions applicable to outpatient Laboratory Services, see page GH 411 G.
- For payment conditions applicable to Medical Emergency, see page GH 411 D.

If you or one of your Dependents is referred to another provider, you or your Dependent should verify with the Physician that the referral is for a PPO Provider. Examples of this would be an anesthesiologist, x-ray facilities, surgeons, radiologists, etc. If that provider is not a PPO Provider, the level of benefits for Non-PPO Providers will apply.

BENEFIT MAXIMUMS

Overall Lifetime Maximum Payment Limit	$5,000,000

As described below, there are other Lifetime Maximum Payment Limits applicable to certain medical Treatment or Service. Benefits paid toward all such limits will be counted towards the Overall Lifetime Maximum Payment Limit shown above, and will reduce this maximum accordingly.

Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services	See GH 411 B
Transplant Services Outside the Transplant Network	$500,000 during an insured person's lifetime.
Ambulance Services	$5,000 per person/per calendar year.
Home Health Care	40 visits per person/per calendar year.
Prosthetics	$50,000 during an insured person's lifetime.
Hospice	$25,000 during an insured person's lifetime.
Skilled Nursing Facility Confinement	$800 per day/60 days for all confinements resulting from the same sickness or injury.
Durable Medical Equipment	$2,500 per person/per calendar year.

Your Responsibilities

- **If you use providers outside the PPO network,** your medical ID card includes a toll-free telephone number to call for Hospital Admission Review approvals. You must follow all of the requirements described on page GH 407 CC -- Utilization Management Program or your benefits will be reduced.

- **If you use providers within the PPO network,** your PPO Physician automatically handles the Hospital Admission Review approvals.

  See page GH 146 A for important claim procedures information on filing your medical claims.

- **Prior approval** is also required for certain other services, including, but not limited to:

  - Home Health Care Services
  - Home Infusion Therapy Services
  - Skilled Nursing Facility Confinement

Refer to the Description of Benefits section for specific details on the preapproval requirements for these services.

PRESCRIPTION DRUGS

Benefits Payable

For each prescription and each refill	100% of Covered Charges in excess of the Copay Amount.

Copay Amount For Maintenance Drugs and Medicines:

An amount equal to 3-times the applicable Copay amount shown below for "all other drugs".

Copay Amount for All other Drugs:

For each prescription and each refill:

for Tier 1 Prescription Drugs:	$10.00
for Tier 2 Prescription Drugs	$25.00
for Tier 3 Prescription Drugs and all other drugs:	$40.00

Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member or Dependent must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the Physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.

You will receive a list from Us showing those drugs that are included on the Preferred Brand Name Drugs list. When you receive a prescription from your Physician, you should encourage the Physician to prescribe one of the drugs from the list. Explain that your drug cost is significantly lower when you use a Preferred Brand Name Drug. Your employer also has a copy of this list.

See page GH 432 for a complete description of Prescription Drugs Expense Insurance.

MAIL SERVICE PRESCRIPTION DRUGS

Benefits Payable

For each prescription and each refill	100% of Covered Charges in excess of the Copay Amount.

Copay Amount

For each prescription and each refill:

for Tier 1 Prescription Drugs:	$25.00
for Tier 2 Prescription Drugs	$62.50
for Tier 3 Prescription Drugs and all other drugs:	$100.00

Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member or Dependent must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the Physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.

You will receive a list from Us showing those drugs that are included on the Preferred Brand Name Drugs list. When you receive a prescription from your Physician, you should encourage the Physician to prescribe one of the drugs from the list. Explain that your drug cost is significantly lower when you use a Preferred Brand Name Drug. Your employer also has a copy of this list.

See page GH 433 for a complete description of Mail Service Prescription Drugs Expense Insurance.

HOW TO BE INSURED - MEMBERS

MEDICAL EXPENSE INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

Member means any person who is a Full-Time Employee of the Policyholder.

You will be eligible on the date you complete the Waiting Period.

The Waiting Period is a period of one month during which you are continuously employed as a Member.

Individual Incontestability and Eligibility

All statements made by any person insured (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in Written form Signed by the insured person; and
- a copy of the form which contains the statement is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person's not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, We may, at any time, adjust premiums and benefits to reflect the correct age.

We may at any time terminate a Member's or Dependent's eligibility under the Group Policy:

- in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;
- in Writing and with 31-day notice, upon finding in a civil or criminal case that a Member or Dependent has submitted claims that contain false or fraudulent elements under state or federal law;
- in Writing and with 31-day notice, when a Member or Dependent has submitted a claim which, in good faith judgment and investigation, a Member or Dependent knew or should have known, contains false or fraudulent elements under state or federal law.

Effective Date for Non-Contributory Insurance

Unless you waive coverage in writing and are covered under another group medical policy, Insurance for which you contribute no part of the premium will become effective on the date you are eligible. You must request initial insurance in a form provided by Us.

If request for non-contributory insurance is made more than 31 days after the date an individual is eligible and other than during an Annual Open Enrollment Period or Special Enrollment Period described below, insurance for such individual will become effective as described below for Late Enrollees.

If request for non-contributory insurance is made more than 31 days after the date an individual is eligible but during an

Annual Open Enrollment Period described below, insurance for such individual will become effective as described below under "Annual Open Enrollment Period".

If request for non-contributory insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period described below, insurance for such individual will become effective as described below under "Special Enrollment Periods".

Effective Date for Contributory Insurance

If you are required to contribute towards the cost of your insurance, you must request initial insurance in a form provided by Us. The requested insurance will become effective on:

- the date you are eligible, if the request is made on or before that date; or
- the date of your request, if you make your request within 31 days after the date you are eligible.

If request for contributory insurance is made more than 31 days after the date an individual is eligible and other than during an Annual Open Enrollment Period or Special Enrollment Period described below, insurance for such individual will become effective as described below for Late Enrollees.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but during an Annual Open Enrollment Period described below, insurance for such individual will become effective as described below under "Annual Open Enrollment Period".

If request for contributory insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period described below, coverage for such individual will become effective as described below under "Special Enrollment Periods".

Statement of Health Requirements

A statement of health, in a form provided by Us, may be required from you when you first request insurance under this plan. The statement of health will be used for rating the group, case management or reinsurance purposes. In no event will a person be declined for insurance, or charged an additional premium, due to his or her health status.

Late Enrollment Provisions

- **Definition**

  Late Enrollee. Late Enrollee means, with respect to insurance under an employer's Group Health Plan, a Member or Dependent who enrolls under such plan other than during:

  (1) the first period in which the individual is eligible to enroll under the Group Health Plan; or

  (2) a Special Enrollment Period described below.

  For the purpose of (1) above, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if:

  (1) the individual loses eligibility due to termination of employment or due to a general suspension of the Group Health Plan; and

  (2) the individual later becomes eligible again due to resumption of employment or due to resumption of the Group Health Plan's insurance.

  The term "Late Enrollee" also means a Member or Dependent who:

(1) was previously insured under the Group Policy but elected to terminate the coverage; and

(2) reapplies for insurance more than 31 days after the termination date; and

(3) does not qualify for one of the Special Enrollment Periods described below.

Effective Date for Late Enrollees

If a Late Enrollee requests insurance other than during an Annual Open Enrollment Period or Special Enrollment Period, the effective date of insurance for the Late Enrollee will be the next Policy Anniversary date, provided on such date:

(1) the Member continues to meet the Group Policy's definition of a Member; and

(2) for Dependent insurance, the Dependents continue to meet the Group Policy's definition of Dependent.

The individual will be subject to the Group Policy's Preexisting Condition Exclusion provisions, as described on GH 451, when his or her insurance becomes effective.

Annual Open Enrollment Period

An Annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

(1) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period; or

(2) during any previous Annual Open Enrollment Period; or

(3) within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Open Enrollment Period, the Member or Dependent:

(1) must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable Waiting Period; and

(2) may not be covered under an alternate medical expense coverage offered by the employer, unless the Annual Open Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Open Enrollment Period is the one-month period immediately prior to the Policy Anniversary date. The Policy Anniversary date is August 15.

The effective date for any qualified individual requesting insurance during the Annual Open Enrollment Period will be the day immediately following completion of the Annual Open Enrollment Period.

The individual will be subject to the Group Policy's Preexisting Condition Exclusion provisions, as described on GH 451, when his or her insurance becomes effective.

Special Enrollment Periods

If you or your Dependent request enrollment after the first period in which you or your Dependent were eligible to enroll but during a Special Enrollment Period as described below, you or your Dependent will be a Special Enrollee and will not be considered a Late Enrollee.

The Special Enrollment Periods are:

(1) Loss of Other Coverage: A Special Enrollment Period will apply to an individual (you or your Dependent) if all of the following conditions are met:

(i) the individual was covered under another Group Health Plan or had other Health Insurance Coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and

(ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and

(iii) request for enrollment is made within 31 days after the other coverage terminates.

The effective date of insurance will be the date after the other coverage terminates.

NOTE: For the purpose of (1) (ii) above:

(i) "loss of eligibility" does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of insurance for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health insurance); and

(ii) "employer contributions" include contributions by any current or former employer (of the individual or another person) that was contributing to the insurance of the individual.

(2) Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:

(i) you are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and

(ii) a person becomes your Dependent through marriage, birth, adoption or Placement for Adoption; and

(iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption or Placement for Adoption.

The effective date of your or your Dependent's insurance will be:

(i) in the event of marriage, the date of marriage; or

(ii) in the event of a Dependent Child's birth, the date of such birth; or

(iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

(3) Court-Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). A Special Enrollment Period will apply to you or your Dependent Child if:

(i) you are enrolled (or eligible to be enrolled but have failed to enroll during a previous enrollment period); and

(ii) you have failed to enroll your Dependent Child during a previous enrollment period; and

(iii) you are required by QMCSO or NMSN as defined by federal law and state insurance laws to provide health insurance for your Dependent Child.

The request for enrollment:

(i) may be made at any time after the issue date of the QMCSO or NMSN; and

(ii) will apply only to you and/or your Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for your or your Dependent Child's insurance will be the date of issue of the QMCSO or NMSN.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of this Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

(4) All Other Court-Ordered Coverage. A Special Enrollment Period will apply to your spouse or Dependent Child if:

(i) you are enrolled but have failed to enroll the spouse or Dependent Child during a previous enrollment period; and

(ii) you are required by a court or administrative order to provide health insurance for the spouse or Dependent Child; and

(iii) request for enrollment for a spouse is made within 31 days after the issue date of the court or administrative order.

The effective date of the spouse's or Dependent Child's insurance will be the date of the request for enrollment.

(5) Election to Transfer Coverage. A Special Enrollment Period will apply to you and your Dependents if:

(i) the Policyholder offers employees a choice among health benefit coverages; and

(ii) you elect to transfer from another of the offered coverages to coverage under the Group Policy; and

(iii) request for enrollment is made during an open enrollment period designated by the Policyholder for such transfer.

The effective date of your and your Dependent's insurance under the Group Policy will be the day immediately following the last day of the designated open enrollment period described above.

Effective Date for Benefit Changes

A change in your Scheduled Benefit amount because of a change in your status (insurance class) will be effective on the date of change in status.

A change in the Scheduled Benefits because of a change in the schedule of insurance elected by the Policyholder will be effective on the date of change.

Termination

Unless continued as provided below or on GH 117 A (MED), GH 117 B (MED), GH 117 C (MED) and GH 117 D (MED) your insurance under the Group Policy will cease on the earliest of

- the date the Group Policy terminates; or
- the date you cease to belong to a class for which insurance is provided; or
- the date you cease to be a Member; or
- the date you cease to be actively employed; or
- for Comprehensive Medical Expense Insurance, Prescription Drugs Expense Insurance, and Mail Service Prescription Drugs Expense Insurance, the date you reach the Comprehensive Medical Overall Lifetime Maximum Payment Limit.

Continuation

If you cease to be actively employed because of sickness or injury, your Medical Expense Insurance may be continued until the earlier of the date you recover or the date insurance would otherwise terminate as described above, but in no event longer than 12 consecutive months.

If you cease to be actively employed because of layoff or leave of absence, insurance may be continued on a limited basis.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described on GH 117 A (MED), GH 117 B (MED), GH 117 C (MED), and GH 117 D (MED).

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

HOW TO BE INSURED - DEPENDENT

MEDICAL EXPENSE INSURANCE

Eligibility

You will be eligible for insurance for your Dependents on the later of:

- the date you are eligible for Member insurance; or
- the date you first acquire a Dependent.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member Insurance. If a Member is eligible for Dependent insurance, such insurance will become effective under the same terms as described earlier for Member insurance, except any Statement of Health will be with respect to the health of your Dependents.

If Dependent insurance is then in effect for any other Dependent, a new Dependent will be insured on the date acquired. Request for insurance is not required provided We are notified of the new Dependent within 31 days after the date the Dependent is acquired. With respect to medical benefits for a newborn or newly adopted Dependent Child, effective date provisions are modified as described below.

Insurance for a Newborn or Newly Adopted Child

A newly born or newly adopted Dependent Child will be insured for medical from the moment of birth, or on the date of adoption or Placement for Adoption (whichever is earlier), provided the child meets the definition of a Dependent Child. Any applicable prior application provisions will be waived with respect to such child.

However, if you are required to contribute toward the cost of Dependent insurance, you must notify Us within 31 days after the date of birth, adoption or Placement, in order to continue the child's insurance beyond the 31-day period. If such notice is not given to Us within the 31-day period, the child will be subject to the Late Enrollment provisions. If your request for enrollment is a result of a QMCSO or NMSN, the child will not be a Late Enrollee and is eligible for a Special Enrollment Period as described on GH 115 A (MED).

If the child's insurance terminates because you fail to request insurance (or pay the required contribution) within the 31-day period following the child's date of birth, adoption or Placement, benefits will be payable only for covered expenses incurred by the child during the 31-day period in which insurance was in force. The Individual Purchase Rights and the Extended Benefits (after termination of insurance) will not apply to the child.

Individual Incontestability and Eligibility

Your Dependents will be subject to the Individual Incontestability and Eligibility as described earlier for Member insurance.

Termination

Unless continued as provided on GH 117 A (MED), GH 117 B (MED), GH 117 C (MED), and GH 117 D (MED):

- Insurance for all of your Dependents will terminate on the earliest of:
  - the date you cease to belong to a class for which Dependent insurance is provided; or
  - the date Dependent coverage is removed from the Group Policy; or

- the date your Member insurance ceases.

- Insurance for any one Dependent will terminate on the earlier of:

  - the date he or she ceases to be your Dependent; or

  - for Comprehensive Medical Expense Insurance, Prescription Drugs Expense Insurance, and Mail Service Prescription Drugs Expense Insurance, the date that Dependent reaches the Comprehensive Medical Overall Lifetime Maximum Payment Limit.

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

If you reach the Comprehensive Medical Overall Lifetime Maximum Payment Limit, your Dependent's Medical Expense Insurance, Prescription Drugs Expense Insurance and Mail Service Prescription Drugs Expense Insurance may be continued until the earliest of:

- the date you cease to be a Member; or

- the date Dependent Medical Expense Insurance would otherwise cease as provided above; or

- the date your insurance would have otherwise ceased if you had not exhausted your Comprehensive Medical benefits.

Continuation

In addition, under certain conditions, your Dependent's Medical Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described on GH 117 A (MED), GH 117 B (MED), GH 117 C (MED), and GH 117 D (MED).

CONTINUATION OF INSURANCE

State Required Continuation - Illinois

Definitions

Qualified Person means an individual who, on the day before a Qualifying Event, is covered under the Group Policy by virtue of being the Member or the Dependent Spouse or Dependent Child of the Member.

Qualifying Event means any of the following events which, except for the election to continue coverage, would result in a loss of coverage to a Qualified Person:

- the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy (unless termination of employment was due to the Member's commission of a felony or theft in connection with his or her work, the employer was in no way responsible, and the Member either admitted committing the act or such act resulted in a conviction or order of supervision by a court of competent jurisdiction). In this instance, covered Dependents are eligible for continuation of coverage only if the Member has elected to continue coverage under these provisions; or
- the Member's death; or
- the Member's dissolution of marriage (divorce); or
- the Member's retirement; or
- the Member's Dependent Child attaining the limiting age under the Group Policy.

Qualification for Continuation

A Qualified Person who would lose insurance under the Group Policy because of a Qualifying Event may elect to continue the insurance, if, on the date insurance would otherwise cease:

- the Qualified Person is not eligible under Medicare; and
- the Group Policy is in force.

In addition, the following Qualification provisions apply:

- If the Qualifying Event is the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy, the Member must have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least the three-month period immediately preceding the termination of employment; and
- If the Qualifying Event is the Member's retirement, the Member's spouse must be at least 55 years of age on the date of the Member's retirement; and
- If the Qualifying Event is the Member's Dependent Child attaining the limiting age under the Group Policy, the child is not covered by any other insured or self-insured plan.

Period of Continuation

Persons who qualify for continuation as described above may continue insurance until:

- If the Qualifying Event is the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy, the earliest of:

- the date insurance would otherwise cease as provided in the Group Policy; or
- the date the Member first becomes covered (after electing continuation) under another group medical expense plan; or
- the date insurance has been continued for nine months.

- If the Qualifying Event is the Member's death, dissolution of marriage, or retirement, the earliest of:
  - the date insurance would otherwise cease as provided in the Group Policy. Exception: During the first 120 days after the Qualifying Event, insurance may be terminated only if such termination is due to termination of the Group Policy; or
  - the date the Qualified Person first becomes (after electing continuation) a covered employee under any other group medical expense plan; or
  - the date the Member's former (surviving or divorced) spouse remarries; or
  - if the Qualified Person is under age 55 when continuation begins, the date insurance has been continued for two years; or
  - if the Qualified Person is age 55 or older when continuation begins, the date the Qualified Person becomes eligible for Medicare.
- If the Qualifying Event is the Member's Child attaining the limiting age under the Group Policy, the earliest of:
  - the date the Dependent Child becomes covered by Medicare; or
  - the date insurance would otherwise cease as provided in the Group Policy; or
  - the date on which the Dependent Child first becomes, after the date of election, an insured employee under any other group medical expense plan; or
  - the date insurance has continued for two years.
- For all Qualifying Events, the earliest of:
  - the applicable date specified above; or
  - the end of the premium period for which premium is paid, if the Qualified Person fails to make timely payment of a required premium within the Grace Period; or
  - the date the Group Policy is terminated. (The continuation period may be completed under the Policyholder's replacement coverage if the Member is, or would have been, covered under the replacement policy.)

Notice, Election, and Premium Requirements

If the Qualifying Event is the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy, the employer must give the Member written notice of the continuation right. The Member must request continuation in writing, and pay the initial premium within ten days after the later of: (i) the date insurance would otherwise terminate; or (ii) the date the Member is given written notice of the continuation right. In no event, however, may the Member elect continuation more than 60 days after the date insurance would otherwise end.

If the Qualifying Event is the Member's death, dissolution of marriage, retirement or the Member's Child attaining the limiting age under the Group Policy, the Qualified Person must give the Member's employer or Us written notice of the

Qualifying Event within 30 days after it occurs. Within 15 days after receipt of that notice, the employer must: (i) send notice of the Qualifying Event to Us and (ii) send a copy of the notice sent to Us, to the Qualified Person. Within 30 days after receipt of the employer's or Qualified Person's notice, We must send the Qualified Person information concerning continuation, including an election form. The Qualified Person must return the completed election form to the employer and pay the initial premium, within 30 days after receipt of the continuation information.

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of your insurance.

A. Qualified Persons/Qualifying Events

Continuation of group health coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following events:

(1) A Member (and any covered Dependents) following the Member's:

(a) termination of employment for a reason other than gross misconduct; or

(b) a reduction in work hours.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member qualifies for COBRA when the Member does not return to work after the end of FMLA leave); and

(2) A Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and

(3) A Member's surviving spouse (and any Dependent Children), following the Member's death; and

(4) A Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and

(5) A Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and

(6) A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and

(7) If the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree health benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months (see Disabled Extension,

Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or

(2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (5) is 36 months.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

(1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.

(2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A(2) through A(5), absent the first qualifying event, results in a loss of coverage for Dependents under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

(1) The date the maximum continuation period ends; or

(2) The date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the

employer's bankruptcy filing as described in A(7); or

(3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or

(4) The date the Group Policy is terminated (and not replaced by another group health plan); or

(5) The date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan; however, this does not apply to a person who is already covered by the other group health plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A(7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent become ineligible and loses group health coverage due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirement

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a Written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make Written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Individual Purchase Rights

When a qualified person is no longer eligible for continued coverage, he/she may apply for Individual Purchase. Persons who are eligible for similar benefits which would result in over-insurance may not purchase conversion coverage. An application for Individual Purchase will be provided 180 days prior to the end of the maximum continuation period. Application for Individual Purchase, and payment of the required premium, must be made within 31 days after the continued coverage ends. Dental, Vision Care, and Prescription Drug coverages are not included with the Individual Purchase Option (however, benefits for prescription drugs are included in the Individual Purchase coverage).

M. Contact Information.

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

SOUMA DIAGNOSTIC LTD Insurance Plan
SOUMA DIAGNOSTIC LTD Benefits Department
351 WALLACE RD
LAKE FOREST IL 60045
847-295-8741

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child.
- The placement of a child with the Eligible Employee for adoption or foster care.
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition".
- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her

job.

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

See your employer for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if your insurance would otherwise end because you enter into active military duty, you may elect to continue insurance (including Dependents' insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because you enter active military duty, insurance may be continued until the earliest of:

- for you and your Dependents:
  - the date the Group Policy is terminated; or
  - the end of the premium period for which premium is paid if you fail to make timely payment of a required premium; or
  - the date 24 months after the date you enter active military duty; or
  - the date after the day in which you fail to return to active employment or apply for reemployment with the Policyholder.
- for your Dependents:
  - the date Dependent Medical Expense Insurance would otherwise cease as provided on GH 125 A; or
  - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

For Medical Expense Insurance, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your Group Policy. See your employer for details on this continuation provision.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE (PAYMENT PROVISIONS)

Payment Conditions

If you or one of your Dependents receives Treatment or Service for a sickness or injury, We will pay Comprehensive Medical benefits for Covered Charges:

- in excess of the Deductible or Copay Amount; and
- at the payment percentages indicated; and
- to the applicable Maximum Payment Limit;

as described in the Summary of Benefits section.

Total benefits payable for each person during his or her lifetime will not be more than the Comprehensive Medical Overall Lifetime Maximum Payment Limit.

Benefit Qualification

To qualify for payment of the benefits provided for an insured class, you and your Dependents must:

- be insured in that class on the date medical Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Benefits Payable - Required by Federal Law

Subject to the benefits payable provisions as described above, benefits will be payable for:

- **Newborns' and Mothers' Health Protection Act of 1996**

  Under Federal law, Group Health Plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a Group Health Plan may not, under Federal law, require that a provider obtain authorization from the Group Health Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

  See "Maternity Coverage" under Benefits Payable - State Required - ILLINOIS below for description of how

benefits will be payable under the Group Policy.

- **Women's Health and Cancer Rights Act of 1998**

  Under Federal law, group health plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

  - all stages of reconstruction of the breast on which the mastectomy has been performed;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses and physical complications of mastectomy, including lymphedemas;

  in a manner determined in consultation between the attending physician and the patient.

  See "Mastectomy" under Benefits Payable - State-Required - ILLINOIS below for a description of how benefits will be payable under the Group Policy.

Benefits Payable - State Required - Illinois

Subject to the benefits payable provisions, as described above, benefits will be payable for:

- **Temporomandibular Joint Disorder and Craniomandibular Disorder**

  Covered Charges will include charges incurred for medically necessary treatment of temporomandibular joint disorder and craniomandibular disorder. Benefits will be payable the same as for any other sickness up to a lifetime maximum benefit of $2,500 for each covered person.

- **Mammography Services**

  Covered Charges will include charges incurred for mammography services. Benefits will be payable the same as for any other Physician Office or Clinic Service.

- **Maternity Coverage**

  Covered Charges will include Hospital Inpatient Confinement charges incurred by a mother and newborn Dependent Child. Benefits will be payable for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean section. Benefits will be payable the same as for any other covered Treatment or Service; however, the 48-hour and 96-hour minimum will not be subject to the Hospital Admission Review or Medically Necessary Care requirements of the Group Policy. Any benefits payable in excess of the 48-hour or 96-hour minimum will be subject to all terms and conditions of the Group Policy that apply to any other covered Treatment or Service.

- **Cancer Screening**

  Covered Charges will include charges incurred for a digital rectal examination and a prostate-specific antigen test for the detection of prostate cancer in men. Covered Charges will also include charges incurred for cervical or Pap smear tests for women. Benefits will be payable the same as for any other Physician Office or Clinic Service.

- **Mastectomy**

  Covered Charges will include Hospital Inpatient Confinement charges incurred for a mastectomy. The length of inpatient care will be determined by the attending Physician based upon:

  - Medically Necessary Care; and

- protocols and guidelines based on scientific evidence; and

- evaluation of the patient.

Covered Charges will also include charges incurred for a post-discharge physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Treatment of Diabetes**

Covered Charges will include the following equipment, supplies, outpatient self-management training, and related services for the treatment of Type I diabetes, Type II diabetes, and gestational diabetes mellitus, when Medically Necessary and prescribed by a Physician. The benefits will be payable on the same basis as for any other covered Treatment or Service.

- **Equipment and Supplies**

  Covered Charges will include: blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets and lancing devices, insulin, syringes and needles, test strips for glucose monitors, FDA approved oral agents used to control blood sugar, and glucagon emergency kits.

- **Outpatient Self-Management Training**

  Covered Charges will include diabetes self-management training. "Diabetes self-management training" means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Training includes the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy. Training may be provided as part of an office visit, group setting, or home visit.

  Coverage for diabetes self-management training is limited to Medically Necessary care for visits to a Physician or certified, registered, or licensed health care professional with expertise in diabetes management upon (i) the diagnosis of diabetes; and (ii) the occurrence of significant change in the patient's symptoms or medical conditions.

- **Related Services**

  Covered Charges will include regular foot care examinations by a Physician.

NOTE: For the purpose of these state-required benefits, the following diabetic supplies will be payable under Prescription Drug Expense Covered Charges or Mail Service Prescription Drug Expense Covered Charges: insulin; disposable insulin needles/syringes; disposable blood/urine glucose acetone testing agents (e.g. Chemstrips, Acetest tablets, and Clinitest tablets); lancets; glucometer (limited to no more than one each calendar year); and alcohol swabs.

All other diabetic supplies will be payable the same as any other covered Treatment or Service under Benefits Payable - State Required - ILLINOIS.

- **Colorectal Cancer Examinations and Laboratory Tests**

Covered Charges will include charges incurred for colorectal cancer examinations and laboratory tests as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the

Centers for Disease Control and Prevention, and the American College of Gastroenterology. Benefits will be payable the same as for any other Physician Office or Clinic Service.

- **Dental Anesthesia and Hospital Charges**

Covered Charges will include charges incurred and anesthetics provided for dental procedures performed in a Hospital or Ambulatory Surgery Center.

Benefits are payable when incurred by:

- your Dependent who is age 6 or under; or
- you or your Dependent, if you or your Dependent is disabled; or
- you or your Dependent, if you or your Dependent has a medical condition that requires hospitalization or general anesthesia for dental care.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Contraceptive Drugs, Devices and Services**

Covered Charges will include charges incurred for outpatient prescription contraceptive drugs or devices that are approved by the United States Food and Drug Administration.

Covered Charges will also include charges for outpatient contraceptive services including consultation, examinations, procedures and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Osteoporosis**

Covered Charges will include coverage for Medically Necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.

Benefits will be payable the same as for any other covered Treatment or Service.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE
COVERED CHARGES

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Covered Charges

Covered Charges will be the actual cost charged to you or one of your Dependents but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Covered Charges for Comprehensive Medical benefits payable will be based on four Categories of medical care services as described below.

Payment of Covered Charges not listed shall be determined by Us based on the amount payable for a Covered Charge of a comparable nature.

- **Hospital Services includes:**
  - charges by a Hospital for room and board (but not more than the Hospital Room Maximum if confinement is in a private room); and
  - Hospital services other than room and board; and
  - charges by a Physician for pathology, radiology, or the administration of anesthesia while receiving treatment during a Hospital Inpatient Confinement (on an inpatient or outpatient basis); and
  - the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided while receiving treatment during a Hospital Inpatient Confinement or as otherwise required by state law; and
  - physical, occupational, and speech therapy, but only when such services are provided while receiving treatment during a Hospital Inpatient Confinement; and
  - charges for blood and blood plasma when provided while the person is receiving treatment during a Hospital Inpatient Confinement; and
  - Birthing Center services; and
  - Ambulatory Surgery Center services; and
  - freestanding dialysis center services; and
  - Inpatient Rehabilitative Services as described in GH 411 F.
- **Physician Hospital Services** include charges for the services of a Physician (including surgery and Physician Visits), while receiving treatment at a Hospital (on an inpatient or outpatient basis).
- **Physician Office or Clinic Services include:**
  - charges for Treatment or Service furnished at the Physician's clinic or office. Such services include charges for a Physician Visit, injections, take-home drugs, blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy. MRIs, CATs, PETs, and SPECTs or other

similar imaging tests are paid under All Other Covered Services as listed below; and
- the services of a Health Care Extender; and
- physical, occupational, and speech therapy as described in GH 411 F.

- **All Other Covered Services include:**

  - drugs and medicines requiring a Physician's prescription and approved by the Food and Drug Administration for general marketing(excluding those charges payable under Prescription Drugs Expense Insurance and Mail Service Prescription Drugs Expense Insurance); and
  - charges for ambulance services provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) or to and from a Hospital when needed to transition to a more cost effective level of care as determined by The Principal; not to exceed a maximum benefit of $5,000 each calendar year for you or one of your Dependents; and
  - surgical dressings, supplies, covered orthotics, casts, splints, braces and crutches and equipment not considered to be Durable Medical Equipment as described in GH 411 J; and
  - oxygen, nebulizers and related charges; and
  - Skilled Nursing Facility Care as described in GH 411 M; and
  - Hospice Care as described in GH 411 L; and
  - Home Health Care as described in GH 411 I; and
  - Home Infusion Therapy Services as described in GH 411 I; and
  - Durable Medical Equipment as described in GH 411 J; and
  - Prosthetics as described in GH 411 K; and
  - the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided as part of Home Health Care, Home Infusion Therapy Services or Hospice Care or as required by state law; and
  - anesthesia; and
  - cornea or skin transplants; and
  - magnetic resonance imaging (MRIs), computerized axial tomography (CATs), positron emission tomography (PETs), and single photon emission computerized tomography (SPECTs), or other similar imaging tests and all related services (other than evaluation and management services) including but not limited to drugs and supplies; and
  - Dental Services to repair damages to the jaw and sound natural teeth, if the damage is the direct result of an accident which occurs while the insured person claiming benefits is covered under the Group Policy and if the Dental Services are completed within twelve months after the accident. Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results; and

Covered Charges for Multiple Surgical Procedures

If you or one of your Dependents undergo two or more procedures during the same anesthesia period, Covered Charges for the services of a Physician, facility or other covered provider for each procedure that is clearly identified and defined as a separate procedure will be based on:

- 100% of Prevailing Charges for the first or primary procedure; and
- 50% of Prevailing Charges for the second procedure; and
- 25% of Prevailing Charges for each of the other procedures.

Covered Charges for an Assistant during Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if the skill level of a Medical Doctor or Doctor of Osteopathy would be required to assist the primary surgeon. Covered Charges for such services will be paid up to 20% of Prevailing Charges of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

In addition, the multiple surgical procedure percentiles, as described above will be applied.

Period of Confinement

For purposes of applying the Hospital charges Copay amount for each admission, two or more periods of Hospital Inpatient Confinement will be considered one period of confinement unless caused by an unrelated sickness or injury, or unless separated by 30 consecutive days or more.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

MENTAL HEALTH OR BEHAVIORAL TREATMENT SERVICES AND ALCOHOL OR DRUG ABUSE TREATMENT SERVICES

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Benefits Payable - Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services

The following benefits will be payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this booklet, except as otherwise indicated in this section. In the event you or one of your Dependents receives Treatment or Service for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.

Mental Health or Behavioral Treatment Services

- **Inpatient Hospital Services**

  If you or one of your Dependents is Hospital Inpatient Confined in a Psychiatric Hospital, a psychiatric unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

  Benefits will be payable as described in Benefits Payable below for not more than 10 days of inpatient services each calendar year for each insured person. Each day of Partial Hospitalization or Day Treatment Services, as described in Partial Hospitalization or Day Treatment Services below, will reduce this 10-day benefit by one day.

- **Partial Hospitalization or Day Treatment Services**

  If you or one of your Dependents receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in Benefits Payable below.

  Partial Hospitalization or Day Treatment Services are subject to the Inpatient Hospital Services 10-day calendar year limit. Each day of Partial Hospitalization or Day Treatment Services will reduce the Inpatient Hospital Services 10-day calendar year benefit by one day.

  "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

  "Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a

Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Outpatient Services**

If you or one of your Dependents receives any Outpatient Services by a Physician or Health Care Extender, Hospital, or Community Mental Health Center, benefits will be payable as described in Benefits Payable below for up to 12 visits for each insured person each calendar year.

"Outpatient Services" mean Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy;
- group therapy;
- electroconvulsive therapy;
- psychiatric medication management;
- biofeedback;
- behavior modification treatment;
- hypnotherapy;
- narcosynthesis.

- **Physician Visits**

If you or one of your Dependents receives any Mental Health or Behavioral Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under Benefits Payable below.

- **While Receiving Partial Hospitalization or Day Treatment Services:**Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under Benefits Payable below.

- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be payable as described under Benefits Payable below. Covered Services will be those listed under Outpatient Services above.

- **Benefits Payable**

- **Inpatient Hospital Services:** Benefits will be payable as follows:

  - 60% of Covered Charges if medical care is received from PPO Providers; and
  - 50% of Covered Charges if medical care is received from non-PPO Providers.

Benefits will be subject to the same Deductible or Copay that applies to any other Hospital Inpatient Confinement, as well as the calendar year maximum benefit described above.

Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.

- **Partial Hospitalization or Day Treatment Services:** Benefits will be payable on the same basis as described above for Inpatient Hospital Services and subject to the calendar year Deductible, as well as the calendar year maximum benefit described above.

- **Outpatient Services:** Benefits will be payable as follows:

  - 60% of Covered Charges if medical care is received from PPO Providers; and
  - 50% of Covered Charges if medical care is received from non-PPO Providers.

  Benefits payable will be subject to the same Deductible or Copay that applies to any other Outpatient Services, as well as the calendar year maximum benefit described above.

- **Physician Visits:** Benefits will be payable as follows:

  - 60% of Covered Charges if medical care is received from PPO Providers; and
  - 50% of Covered Charges if medical care is received from non-PPO Providers.

  Benefits payable will be subject to any applicable per-visit Copay or the calendar year Deductible as well as the applicable limit described in Physician Visits as shown above.

Alcohol or Drug Abuse Treatment Services

- **Inpatient Hospital Services**

  If you or one of your Dependents is Hospital Inpatient Confined in an Inpatient Alcohol or Drug Treatment Facility or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. Benefits will be payable as described in Benefits Payable below.

- **Partial Hospitalization or Day Treatment Services**

  If you or one of your Dependents receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in Benefits Payable below, not to exceed a maximum benefit of 30 days each calendar year for each insured person.

  "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

  "Partial Hospitalization or Day Treatment Services" means a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Outpatient Services**

  If you or one of your Dependents receives any Outpatient Services by a Physician or Health Care Extender, Hospital or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described in Benefits Payable below, for up to 25 visits for each insured person each calendar year.

  "Outpatient Services" means Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

- individual therapy;
- group therapy;
- alcohol or drug abuse medication management;
- biofeedback;
- behavior modification treatment;
- alcohol or drug abuse rehabilitation or counseling services.

- **Physician Visits**

If you or one of your Dependents receives any Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under Benefits Payable below.

- **While Receiving Partial Hospitalization or Day Treatment Services:**Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described below.

- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be payable as described under Benefits Payable below. Covered Services will be those listed under Outpatient Services above.

- **Benefits Payable**

- **Inpatient Hospital Services:** Benefits will be payable the same as for any other sickness and will be subject to the same Deductible that applies to any other Hospital Inpatient Confinement.

  Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.

- **Partial Hospitalization or Day Treatment Services:** Benefits will be payable the same as for any other sickness and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described above.

- **Outpatient Services:** Benefits will be payable as follows:

  - 60% of Covered Charges if medical care is received from PPO Providers; and
  - 50% of Covered Charges if medical care is received from non-PPO Providers.

  Benefits will be subject to the same Deductible that applies to any other Outpatient Services, as well as the calendar year maximum benefits described above.

- **Physician Visits:** Benefits will be payable as follows:

  - 60% of Covered Charges if medical care is received from PPO Providers; and
  - 50% of Covered Charges if medical care is received from non-PPO Providers.

  Benefits payable will be subject to any applicable per-visit Copay or the calendar year Deductible.

Provisions Applicable to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment

Services

For the purpose of the benefits described in this subsection:

- With the exception of Hospital Inpatient Confinement and Partial Hospitalization or Day Treatment Services for Alcohol or Drug Abuse Treatment Services, charges for Mental Health or Behavioral Treatment Services or Alcohol or Drug Abuse Treatment Services will not apply toward the Out-of-Pocket Expense limits and will never be paid at 100%.

- No benefits will be payable for any charges incurred in excess of the limits and maximums described in Benefits Payable - Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. The general Comprehensive Medical limitations as described in GH 411 O will apply to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. In addition, Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:

  - residential mental health or behavioral Treatment or Service; or

  - recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or

  - psychoanalysis and aversion therapy; or

  - Social Detoxification; or

  - after-care treatment programs for alcohol or drug abuse.

- Notwithstanding the above, Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other sickness and are not subject to the limits described above.

Benefits payable for medical care received from either a Preferred Provider or a Non-Preferred Provider will be combined and applied toward the limits and maximums described.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

TRANSPLANT SERVICES

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Benefits Payable - Transplant Services

"Transplant Services" mean Covered Charges incurred in connection with the Covered Transplants listed below that are a Covered Charge and not considered to be an Experimental or Investigational Measure. The following benefits will be payable for Treatment or Service for Transplant Services. These benefits will be payable instead of any other benefits described in this Group Policy, except as otherwise provided in this section.

- **Covered Transplants**

  The following human-to-human organ or bone marrow transplant procedures will be considered Covered Charges, subject to all limitations and maximums described in this section, for a patient who is covered under the Group Policy.

  - Heart;
  - Heart/lung (simultaneous);
  - Lung;
  - Liver;
  - Kidney;
  - Kidney-pancreas;
  - Pancreas;
  - Small bowel;
  - Bone marrow transplant or peripheral stem cell infusion for the following conditions when a positive response to standard medical treatment or chemotherapy has been documented. Unless otherwise indicated, coverage is for one transplant or infusion only within a 12-month period.

    - Acute Lymphoblastic Leukemia - Autologous bone marrow transplant or peripheral stem cell infusion;
    - Acute Lymphoblastic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Acute Myelogenous Leukemia - Autologous bone marrow transplant or peripheral stem cell infusion;
    - Acute Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Chronic Lymphocytic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Chronic Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion; donor leukocytes are covered following relapse post marrow transplant;

- Aplastic Anemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Hodgkin's Disease - Autologous bone marrow transplant or peripheral stem cell infusion;
- Hodgkin's Disease - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Multiple Myeloma - Autologous bone marrow transplant or peripheral stem cell infusion; single or tandem (two transplants or perfusions within 12 months of each other);
- Multiple Myeloma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Pediatric Neuroblastoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Primary Amyloidosis - Autologous bone marrow transplant or peripheral stem cell infusion;
- Myleodysplasia with refractory anemia - Allogeneic bone marrow transplant or peripheral stem infusion;
- Pediatric Monosomy 7 - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- SCID (Severe Combined Immunodeficiency Disease) - Allogeneic bone marrow transplant or stem cell infusion;
- Thalassemia - Allogeneic bone marrow transplant or stem cell infusion.

The following non-myeloablative regimens are considered Covered Charges, subject to all limitations and maximums described in this section, for a patient who is covered under the Group Policy:

- Multiple Myeloma - Allogeneic bone marrow transplant or stem cell infusion;
- Non-Hodgkin's Lymphoma - Allogeneic bone marrow transplant or stem cell infusion;
- Chronic B-Cell Lymphocytic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion; donor leukocytes are covered following relapse post marrow transplant.

Cornea and skin transplants are not Covered Transplants for the purpose of this Section. Instead, cornea and skin transplants are covered under the normal provisions of this Comprehensive Medical section, and are not subject to any conditions set forth in this Section.

As technology changes, the above referenced Covered Transplants will be subject to modifications when appropriate.

- **Covered Charges**

For the purpose of this section, Transplant Services Covered Charges will include all services listed in the general Comprehensive Medical Covered Charges section, including, but not limited to, services by a Home Health Care Agency, Skilled Nursing Facility, Hospice, and services for Home Infusion Therapy Services and Durable Medical Equipment.

Covered Charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage.

- **Benefits Payable: Within the Transplant Network**

For Transplant Services provided by a provider in the Transplant Network, benefits payable for Treatment or Service received each calendar year will be paid at the PPO level of benefits, subject to the calendar year Deductible.

If transplant related services are provided by a provider in the Transplant Network, travel and lodging expenses for the patient and the patient's Immediate Family will be covered if the treating facility is greater than 100 miles one way from the patient's home (excluding travel or lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Comprehensive Medical ambulance benefit, if such expenses are incurred solely to meet timing requirements imposed by the transplant. Benefits payable cannot be used to satisfy any Deductible or coinsurance amount under the ambulance benefit in the normal provisions of the Comprehensive Medical section.

Travel and lodging benefits will be payable at 100% without application of any Deductible Amount, up to a lifetime maximum benefit of $5,000 for each transplant recipient.

All travel and lodging benefits must be approved in advance by The Principal.

As used in this Section, "Transplant Network" means United Resource Networks.

- **Benefits Payable: Outside the Transplant Network**

For Transplant Services provided by any covered provider other than a Transplant Network Provider, benefits will be payable the same as any other covered Treatment or Service, subject to the calendar year Deductible and the applicable coinsurance rate, up to the following maximum benefits for each transplant episode for each surgery listed below, and up to a lifetime maximum benefit of $500,000 for each insured Member or Dependent:

Liver	$250,000
Kidney	$250,000
Heart	$250,000
Lung	$250,000
Heart/Lung (simultaneous)	$250,000
Bone Marrow	
Autologous	$250,000
Allogeneic	$250,000
Kidney-Pancreas (simultaneous)	$250,000
Kidney	$250,000
Pancreas	$250,000
Small bowel	$250,000

Services subject to the transplant episode and lifetime maximums will include Covered Charges as specified in this section, including, but not limited to: evaluation; pre-transplant, transplant, and post-transplant care (not including outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant services by a Home Health Care Agency, Hospice, Skilled Nursing Facility, and services for Home Infusion Therapy Services and Durable Medical Equipment will reduce those provisions maximums.

No benefits will be payable for travel and lodging expenses if services are provided outside the Transplant Network.

- **Limitations: Applicable Within and Outside the Transplant Network**

The general Comprehensive Medical limitations as described in GH 411 O will apply to Transplant Services. In addition, limitations specific to Home Health Care, Home Infusion Therapy Services, Durable Medical Equipment, Hospice, and Skilled Nursing Facility provisions will apply to Transplant Services if those benefits are used in connection with a Covered Transplant.

For each transplant episode Covered Charges will include:

- Transplant evaluations from no more than two transplant providers; and
- No more than one listing with the United Network of Organ Sharing (UNOS).

If the transplant is not a Covered Transplant under the Group Policy, all charges related to the transplant and all related complications will be excluded from payment under the Group Policy, including, but not limited to,

dose-intensive chemotherapy.

Benefits paid for Transplant Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

MEDICAL EMERGENCY

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Total benefits payable for each person during his or her lifetime will not be more than the Comprehensive Medical Overall Lifetime Maximum Payment Limit.

Medical Emergency

If a you or one of your Dependents require treatment for a Medical Emergency, either within the PPO Service Area or outside the PPO Service Area, and cannot reasonably reach a Preferred Provider, benefits for such treatment received for that Medical Emergency will be paid as if the treatment had been provided by a Preferred Provider. Treatment or Service for conditions other than that which created the Medical Emergency will be paid at the Non-PPO level.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

WELLNESS SERVICES

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Wellness Services

- **Routine Physical Exams**
  - **Adult Wellness**
    - If medical care is received from Preferred Providers, charges incurred for Routine Physical Exams will be payable as described below:
    - For you or your Dependent 19 years of age or older: Benefits will be payable at the PPO level the same as for any other Physician Office or Clinic Service, but will be limited to a calendar year maximum benefit of $300 for each insured person.

      If services are provided by a Non-PPO provider, benefits will be payable the same as for any other covered Treatment or Service.
  - **Well Child Visits**
    - Dependents under age 19: If services are provided by a PPO Provider, benefits will be payable at the PPO level the same as for any other Physician Office or Clinic Service.

      If services are provided by a Non-PPO provider, benefits will be payable at the Non-PPO level the same as for any other Physician Office or Clinic Service.

"Routine Physical Exam" means a medical examination given by a Physician for a reason other than to diagnose or treat a suspected or identified sickness or injury. Included as part of the examination are x-rays, laboratory tests, immunizations and other tests given in connection with the examination. Not included are charges for magnetic resonance imaging (MRIs); computerized axial tomography (CATs); and positron emission tomography (PETs), and single photon emission computerized tomography (SPECTs) or other similar imaging tests.

Also not included are charges for Mammography Services, Cancer Screening, and Colorectal Cancer Examinations and Laboratory Tests. Such charges are payable as described under GH 410.

- **Pediatric Vaccines**

  Covered Charges will include the cost of Pediatric Vaccines administered to a Dependent Child from birth through 18 years of age.

"Pediatric Vaccines" mean those vaccines shown on the list established and periodically reviewed by the Advisory Committee on Immunization Practices as referenced by Section 1928 of Title 19 of the Social Security Act or such other list of vaccines as mandated by other Federal or State laws that are applicable to this Group Policy.

Benefits for Pediatric Vaccines will be paid the same as any other Physician Office or Clinic Service.

- **Screening Colonoscopies**

Refer to GH 410 - Benefits Payable - State Required - ILLINOIS.

- **Mammograms**

Refer to GH 410 - Benefits Payable - State Required - ILLINOIS.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

REHABILITATIVE SERVICES

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Rehabilitative Services

- **Outpatient, Office or Clinic Services**
  - **Back, Neck and Spine**

    Covered Charges will include charges for all services incurred for diagnosis and non-surgical treatment (including post-surgical therapy) of the vertebrae, disc, spine, back, neck and adjacent tissues in an outpatient, office or clinic setting. Benefits will be payable the same as any other covered Treatment or Service up to a maximum benefit of $1,000 each calendar year for each insured person.

  - **Occupational Therapy, Physical Therapy and Speech Therapy, excluding Back, Neck and Spine as described above**

    Covered Charges will include charges incurred for occupational therapy, physical therapy and speech therapy, excluding services described above for back, neck and spine, up to a combined maximum benefit of $2,500 each calendar year for each insured person. Benefits will be payable the same as any other Specialist Physician Office or Clinic Service regardless of location of service.

- **Inpatient Services**

  Covered Charges will include charges incurred for inpatient rehabilitative services in an Inpatient Rehabilitation Facility for each insured person during the Member's or Dependent's lifetime. Benefits will be payable the same as any other covered Treatment or Service up to a maximum of 30 days per calendar year.

  "Inpatient Rehabilitation Facility" is a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation bed) that provides rehabilitation health services (including but not limited to physical therapy, occupational therapy or speech therapy) on an inpatient basis, as authorized by law.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

OUTPATIENT X-RAY AND OUTPATIENT LABORATORY SERVICES

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Outpatient X-Ray Services

Payment of outpatient x-ray services will be made as follows:

- The PPO level of benefits will be paid only to Preferred Providers.
- If you or one of your Dependents goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the x-ray(s) to a PPO facility for interpretation, the PPO level of benefits will be paid. If you or your Dependent are not seen within that facility, the Physician Office or Clinic Service per-visit Copay, if any, will not apply, but the PPO level of benefits will be paid.
- If you or one of your Dependents goes to a PPO freestanding x-ray facility, the Physician Office or Clinic Service per-visit Copay, if any, will apply and the PPO level of benefits will be paid. If the x-ray facility is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

Outpatient Laboratory Services

LabOne is a laboratory provider that conducts outpatient testing. We have entered into an agreement with LabOne to provide these services at a negotiated rate.

"Laboratory Services" mean Covered Charges for testing of materials, fluids or tissues obtained from patients for the purpose of screening, diagnosing or monitoring a condition and for determining appropriate treatment.

When you or your dependents require outpatient Laboratory Services, you or your Physician may choose any laboratory you wish. However, if you use the services of a LabOne facility, the benefits will be more favorable.

When utilizing a LabOne facility, there are two ways in which laboratory work is completed:

- specimens are drawn at the Physician's office and are sent to LabOne for testing; or
- the insured visits a LabOne patient service center with a Physician's directive and has the specimen drawn. The specimen is then sent to the centralized laboratory for testing.

If you or a Dependent go to a PPO or Non-PPO Physician's office or clinic and the Physician sends the laboratory work to a LabOne facility for processing, We will pay 100% of Covered Charges for the Laboratory Services. No Copay or Deductible will be applied to these services.

If you or a Dependent go to a LabOne facility with a Physician's directive, We will pay 100% of Covered Charges for the Laboratory Services. No Copay or Deductible will be applied to these services. If the laboratory facility is not a LabOne facility, the level of benefits for Non-PPO Providers will apply.

If you or a Dependent go to a PPO or Non-PPO Physician's office or clinic and the Physician does not send the laboratory work to LabOne facility but instead sends the laboratory work to a PPO facility for processing, the PPO level of benefits will be paid. If you or your Dependent are not seen by that facility, the Physician Office or Clinic Service per-visit Copay, if any, will not apply, but the PPO level of benefits will be paid.

If you or a Dependent go to a LabOne facility, We will pay 100% of Covered Charges for the Laboratory Services. If the laboratory facility is not a LabOne facility but is a PPO facility, the Physician Office or Clinic Service per-visit Copay, if any, will apply and the PPO level of benefits will be paid. If the facility is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

EMERGENCY ROOM SERVICES

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Emergency Room Services

Benefits payable for Treatment or Service at an emergency room will be subject to Copays, Deductibles, and coinsurance in the following order:

- First, the emergency room Copay will be applied; and
- Then, the calendar year Deductible; and
- Last, the applicable coinsurance percentage will be applied.

The emergency room Copay amount, if any:

- will be waived if the insured is admitted to the Hospital immediately following emergency room treatment; and
- will not count toward satisfaction of the calendar year Deductible and will continue to apply after the Out-of-Pocket Expense limit has been satisfied.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

HOME HEALTH CARE AND HOME INFUSION THERAPY

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Home Health Care

- **Covered Charges**

  Covered Charges will include charges by a Home Health Care Agency for:

  - part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.) ; and
  - part-time or intermittent home care by a Home Health Aide; and
  - physical, occupational, speech, or respiratory therapy; and
  - intermittent services of a registered dietician or social worker; and
  - drugs and medicines which require a Physician's prescription, (except as specified under Home Infusion Therapy Services), as well as other supplies prescribed by the attending Physician; and
  - laboratory services (except as specified under Home Infusion Therapy Services).

  The Home Health Care Services must be:

  - rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:
    - prescribed by the attending Physician; and
    - established prior to the initiation of the Home Health Care Services; and
  - preapproved by Us prior to the initiation of the Home Health Care Plan, or in the event that services are required on a weekend, We must be notified the next following business day. If Home Health Care Services are not preapproved by Us, no benefits will be payable.

  In addition, the attending Physician must certify that Home Health Care Services are necessary to prevent, delay or shorten Hospital Inpatient Confinement or Skilled Nursing Facility Confinement.

- **Benefits Payable**

  Benefits will be payable the same as for any other covered Treatment or Service up to a maximum of 40 Home Health Care visits per calendar year for each insured person. For each covered provider, up to four hours of continuous service will be counted as one visit. Covered providers include a: Home Health Aide, registered nurse (R.N.), licensed practical nurse (L.P.N.), registered dietician, social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, or any other member of the Home Health Care team.

  Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this

maximum will be reduced by the benefits paid.

- **Limitations**

The general Comprehensive Medical limitations listed in GH 411 O will apply to Home Health Care. In addition, Home Health Care Covered Charges will not include charges for:

- more than 40 Home Health Care visits in a calendar year for each insured person; or
- nursing, laboratory or therapy services rendered as part of Home Infusion Therapy Services; or
- services provided by you or your Dependent's Immediate Family or any other person residing in the home; or
- Custodial Care.

Home Infusion Therapy Services

- **Covered Charges**

Covered Charges will include charges by a Home Health Care Agency, home infusion company or infusion suite for the following services:

- intravenous chemotherapy;
- intravenous antibiotic therapy;
- intravenous steroidal therapy;
- intravenous pain management;
- intravenous hydration therapy;
- intravenous antiretroviral and antifungal therapy;
- intravenous inotropic therapy;
- total parenteral nutrition;
- intravenous gamma globulin;
- intrathecal and epidural;
- blood and blood products;
- injectable antiemetics;
- injectable diuretics; and
- injectable anticoagulants.

The Home Infusion Therapy Services must be:

- rendered in accordance with a prescribed treatment plan. The treatment plan must be:
  - set up prior to the initiation of the Home Infusion Therapy Service; and
  - prescribed by the attending Physician; and
  - preapproved by Us prior to the initiation of the Home Infusion Therapy Services, or in the event that services are required on a weekend, We are notified the next following business day. If Home Infusion Therapy Services are not preapproved by Us, no benefits will be payable.

In addition, the attending Physician must certify that Home Infusion Therapy Services are necessary to prevent, delay or shorten Hospital Inpatient Confinement or Skilled Nursing Facility confinement.

Covered Charges will be limited to: drugs; intravenous solutions; Durable Medical Equipment; pharmacy compounding and dispensing services; fees associated with drawing blood for the purpose of monitoring response to therapy; ancillary medical supplies; and nursing services for intravenous restarts and dressing changes; and nursing services required due to a Medical Emergency.

- **Benefits Payable**

Benefits will be payable the same as for any other covered Treatment or Service. Benefits payable will be

based on Our allowable charge, which is the amount established by Us at the time services are preapproved. The maximum allowable charge for drugs and medicines for Home Infusion Therapy Services will be established by Us at the time services are preapproved and will not exceed the Average Wholesale Price.

Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

Limitations

The general Comprehensive Medical limitations listed in GH 411 O will apply to Home Infusion Therapy Services. In addition, Home Infusion Therapy Covered Charges will not include charges for:

- services or supplies which are provided under any other section of this booklet for services, drugs, equipment, or supplies used in Home Infusion Therapy Services, except as specifically provided for in this section; or
- services or supplies for any Home Infusion Therapy Services not specifically provided for in this section; or
- services or supplies for any nursing visits, care or services associated with Home Infusion Therapy Services other than those identified in this section; or
- services or supplies for other services required to administer therapy in the home setting, but which do not involve direct patient contact, including, but not limited to, delivery charges and record keeping; or
- services provided by any person who is in your Immediate Family or any other person residing in the home.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

DURABLE MEDICAL EQUIPMENT

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Durable Medical Equipment

- **Covered Charges**

  Covered Charges will include charges for rental or purchase of Durable Medical Equipment. Durable Medical Equipment means equipment that:

  - can withstand repeated use; and
  - is primarily and customarily used to serve a medical purpose; and
  - is generally not useful to a person who is not sick or injured, or used by other family members; and
  - is appropriate for home use; and
  - improves bodily function caused by sickness or injury, or further prevents deterioration of the medical condition.

  Covered Charges will include repair, adjustment or replacement of purchased Durable Medical Equipment, unless damage results from negligence or abuse of such equipment by you or one of your Dependents.

- **Benefits Payable**

  Benefits will be payable the same as for any other covered Treatment or Service up to a maximum benefit of $2,500 each calendar year. However, the Covered Charge for rental of Durable Medical Equipment will be limited to the purchase price of the said piece of equipment. If no purchase price is available, the purchase price will be limited to 1.5 times the manufacturer's invoice price. The determination as to whether to purchase or rent the equipment is at the sole discretion of The Principal.

  Claims submitted for Durable Medical Equipment must be accompanied by the Physician's Written prescription of necessity. However, this prescription does not by itself entitle you or your Dependent to benefits.

  Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

- **Limitations**

The general Comprehensive Medical limitations listed in GH 411 O will apply to Durable Medical Equipment charges. In addition, Durable Medical Equipment Covered Charges will not include Durable Medical Equipment charges which:

- are in excess of the purchase price of the equipment; or
- are for Durable Medical Equipment used in Home Infusion Therapy Services, except as provided above; or
- are provided during rental for repair, adjustment, or replacement of components and accessories necessary for the functioning and maintenance of covered equipment, as this is the responsibility of the Durable Medical Equipment supplier; or
- are motorized carts or scooters, except for wheelchairs: or
- are non-hospital type beds: or
- are lift chairs.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

PROSTHETICS

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Prosthetics

- **Covered Charges**

  Covered Charges will include charges for prosthetic devices (including external electronic voice boxes and similar hand held communication devices after laryngectomy) and supplies which replace all or part of:

  - an absent body part (including contiguous tissue) resulting from sickness, injury, or congenital anomalies); or
  - the function of a permanently inoperative or malfunctioning body part.

  Covered Charges will include the purchase, fitting, and necessary adjustment or replacement of the prosthetic device. In addition, Covered Charges will include cleaning and repairs, unless damage results from negligence or abuse of the prosthetic device by you or one of your Dependents.

- **Benefits Payable**

  Benefits will be payable the same as for any other covered Treatment or Service, up to a lifetime maximum benefit of $50,000 for each insured person. Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

- **Limitations**

  The general Comprehensive Medical limitations listed in GH 411 O will apply to prosthetic charges. In addition, Prosthetic Covered Charges will not include prosthetic charges which:

  - are in excess of the limits and maximums described in this subsection; or
  - are for prosthetic charges that are not prescribed by the attending Physician; or
  - are for dental implants.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

HOSPICE CARE

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Hospice Care

- **Covered Charges**

  Covered Charges will include charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility for:

  - any terminally ill individual (you or any one of your Dependents) who chooses to participate in a Hospice Care Program rather than receive medical treatment to promote cure, and who, in the opinion of the attending Physician, is not expected to live longer than 6 months; and
  - the family of such individual (you or any one of your Dependents);

  but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program.

  Hospice Care Services consist of:

  - inpatient and outpatient hospice care, home care, nursing care, homemaking services, dietary services, social counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual; and
  - medical equipment, drugs and medicines (requiring a Physician's prescription) prescribed for the dying individual by any Physician who is a part of the Hospice Care Team; and
  - instructions for care of the patient, social counseling, and other supportive services for the family of the dying individual.

- **Benefits Payable**

  Benefits will be payable the same as for any other Treatment or Service. However, the maximum benefit payable for any combination of Covered Charges described under Hospice Care Services will be limited to a lifetime maximum benefit of $25,000 (excluding charges for Hospital Inpatient Confinement) for each insured person. Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

- **Limitations**

The general Comprehensive Medical limitations listed in GH 411 O will apply to Hospice Care. In addition, Hospice Care Covered Charges will not include Hospice Care charges that:

- are in excess of the limits and maximums described in this subsection; or
- are for Hospice Care Services not approved by the attending Physician and Us; or
- are for transportation services; or
- are for Hospice Care Services provided at a time other than while provided in a Hospice Care Program.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

SKILLED NURSING FACILITY CONFINEMENT

Benefits Payable

Benefits payable will be as described in the following section, subject to:

- all listed limitations; and
- all Payment Provisions as listed on GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

Skilled Nursing Facility Confinement

- **Covered Charges**

  If you or a Dependent is confined in a Skilled Nursing Facility, Covered Charges will include any charges incurred for room, board, and other services required for treatment, provided:

  - you or Dependent requires daily skilled nursing or skilled rehabilitation care on an inpatient basis as determined by Us; and
  - the Skilled Nursing Facility confinement immediately follows a Hospital Inpatient Confinement for which benefits were payable under this Group Policy; and
  - the Skilled Nursing Facility confinement results from the sickness or injury that was the cause of the Hospital Inpatient Confinement; and
  - the Skilled Nursing Facility confinement begins not later than 14 days after the end of Hospital Inpatient Confinement or begins not later than 14 days after the end of a prior Skilled Nursing Facility confinement for which benefits were payable under the Group Policy; and
  - inpatient Skilled Nursing Facility confinement is certified by a Physician as necessary to treat a sickness or injury.

  The requirements for prior Hospital Inpatient Confinement will be waived if pre-approved by Us. If not pre-approved, and the Skilled Nursing Facility care does not follow Hospital Inpatient Confinement as described, no benefits will be payable.

- **Benefits Payable**

  Benefits will be payable the same as for any other Treatment or Service, not to exceed a maximum benefit of:

  - $800 for any one day of Skilled Nursing Facility confinement; and
  - 60 days for all Skilled Nursing Facility confinements that result from the same or related sickness or injury.

  The following services will not be subject to the Skilled Nursing Facility confinement maximums as stated above: drugs and medicines (requiring a Physician's prescription) that are not billed by the Skilled Nursing

Facility, visits by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), Durable Medical Equipment, and x-ray or laboratory services.

Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

- **Limitations**

The general Comprehensive Medical limitations in GH 411 O will apply to Skilled Nursing Facility confinements. In addition, Skilled Nursing Facility Covered Charges will not include Skilled Nursing Facility confinement charges billed by the Skilled Nursing Facility that:

- are in excess of the limits and maximums described in this section; or
- are incurred on or after the date the attending Physician stops treatment or ceases to prescribe Skilled Nursing Care.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

LIMITATIONS

Limitations

Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not a Covered Charge; or
- Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure prescribed in the notice of that claim decision); or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is in your Immediate Family; or any person in your Dependent's Immediate Family; or
- Dental Services or materials, including dental implants, except as described under Covered Charges; or
- eye examinations for the correction of vision or the fitting of glasses; vision materials including but not limited to frames or lenses; or
- hearing aids; or
- acupressure treatment; acupuncture treatment
- drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing; or
- vitamins, minerals (except prescription potassium supplements), whether or not they require a Physician's prescription; or
- nutritional supplements (even if the only source of nutrition), or special diets (whether or not they require a Physician's prescription); or
- wigs or hair prostheses; or
- Treatment or Service for Cosmetic Treatment and Services unless the Cosmetic Treatment or Service results from a sickness or an accidental injury; and unless the Cosmetic Treatment or Service is completed within 18 months after the date of that sickness or injury; or
- personal hygiene, comfort, or convenience items, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, hoyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators or lift; adaptive equipment for the purpose of aiding in the performance of Activities of Daily Living including, but not limited to dressing, bathing, preparation or feeding of meals; or
- "barrier free" home modifications, whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, railings or standing frames; or
- non-implantable communication-assist devices, including, but not limited to, communication boards, and

computers; or

- Treatment or Service for work-hardening programs or vocational rehabilitation services; or
- Treatment or Service leading to, in connection with, or resulting from sexual transformation or intersex surgery; or
- cryopreservation or storage; or
- Treatment or Service for education or training (except as provided under Treatment of diabetes), developmental delay, or learning disorders; or
- social counseling (except as provided under Hospice Care), marital counseling, or sexual disorder therapy; or
- Treatment or Service for which you or your Dependent have no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless charges are imposed against the person for such Treatment or Service; or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from participation in criminal activities; or
- Treatment or Service for and complications related to:
  - human-to-human organ or bone marrow transplants, except as described under Transplant Services or Covered Charges; or
  - animal-to-human organ or tissue transplants; or
  - implantation within the human body of any Experimental or Investigational Measures for artificial or mechanical devices designed to replace human organs; or
- behavior modification or group therapy, except as provided for under Mental Health or Behavioral Treatment or Services and Alcohol or Drug Abuse Treatment Services; or
- Treatment or Service for smoking cessation or nicotine addiction, gambling addiction, or stress management; or
- Treatment or Service for insertion or revision of breast implants, unless provided post-mastectomy; or
- Treatment or Service for the removal of breast implants unless:
  - the implants were implanted for reconstruction due to sickness or injury; and
  - removal of the implants is Medically Necessary Care for a sickness or injury; or
- Treatment or Service for any sickness or condition for which the insertion of breast implants, or the fact of having breast implants within the body, was a contributing factor, unless the sickness or condition occurs post-mastectomy; or
- Treatment or Service for Kerato-Refractive Eye Surgery for myopia (nearsightedness), hyperopia (farsightedness) or astigmatism; or
- charges for telephone calls or telephone consultations or missed appointments; or
- Treatment or Service covered by medical expense insurance issued under the Individual Purchase Rights

described in this booklet; or

- Treatment or Service that results:
  - from an injury arising out of or in the course of any employment for wage or profit if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the employer who are not covered by a Worker's Compensation Act or other similar law; or
  - from a sickness covered by a Workers' Compensation Act or other similar law; or
- any nursing services (except as described under Covered Charges and as required by state law); or
- Treatment or Service related to the restoration of fertility or the promotion of conception (including reversal of voluntary sterilization); or
- Treatment or Service for foot care with respect to: corns, calluses, trimming of toenails, flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet, casting for orthotics, or any appliance (including orthotics); or
- dietetic counseling, unless provided while you or one of your Dependents is Hospital Inpatient Confined, or as provided under Home Health Care or Hospice Care or Treatment of Diabetes; or
- Treatment or Service by any type of health care practitioner not otherwise provided for in the Group Policy, unless recognition is state mandated; or
- Treatment or Service that is subject to the Preexisting Condition Exclusion described in this booklet; or
- Treatment or Service provided outside the United States, unless such Treatment or Service is for a Medical Emergency; or
- Treatment or Service provided for weight loss or reduction of obesity, including surgical procedures, even if the insured individual has other health conditions which might be helped by weight loss or reduction of obesity; or
- Treatment or Service for Custodial Care; or
- Treatment or Service for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained; or
- Treatment or Service for vision therapy or orthoptic therapy; or
- Treatment or Service that is paid for by a Medicare Supplement Insurance Plan; or
- Charges for e-mail communication or e-mail consultation; or
- Charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by Us; or
- Charges for Physician overhead, including but not limited to surgical suites or rooms, or equipment used to perform the particular Treatment or Service (i.e. laser equipment); or
- Treatment or Services for non-synostotic plagiocephaly; or
- Additional charges incurred because care was provided after hours, on a Sunday, holidays or week-end; or
- Charges for heating pads, heating and cooling units, ice bags or cold therapy units; or

- Treatment or Service for unattended home sleep studies; or
- Treatment or Service for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- Charges for devices used specifically as safety items or to affect performance in sports-related activities; or
- Treatment or Service for gynecomastia (abnormal breast enlargement in males); or
- Charges for sports, employment or immigration physicals; or
- Treatment or Service for hyperhidrosis (excessive sweating); or
- Treatment or Service for complications of a non-covered Treatment or Service; or
- Treatment or Service incurred after termination of coverage under the Group Policy, except as provided under Extended Benefits; or
- Charges for travel and lodging except as indicated under GH 411 C; or
- Charges for transportation services except as described for ambulance services under, All Other Covered Services; or
- Treatment or Services for standby services; or
- Charges for more than one anesthesia provider during the same anesthesia period. Anesthesia provider includes a certified nurse anesthetist or a Physician.

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

UTILIZATION MANAGEMENT PROGRAM

Definitions Applicable to the Utilization Management Program

Concurrent Review

Utilization Review conducted during a patient's Hospital stay or course of treatment.

Continued Stay Review

A review by Us of a Physician's report of the need for continued Hospital Inpatient Confinement to determine if the continued stay is for a Covered Charge.

Health Professional

An individual who:

- has undergone formal training in a health care field; and
- holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and
- has professional experience in providing direct patient care.

Hospital Admission Review

A review by Us of a Physician's report of the need for Hospital Inpatient Confinement (scheduled or emergency) to determine if the confinement is for a Covered Charge.

Initial Clinical Review(er)

Clinical review conducted by appropriate licensed or certified Health Professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification.

Noncertification

A decision by Us that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet Our requirements for a Covered Charge, appropriateness, health care setting level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

Notification of Utilization Review Services

Receipt of necessary information to initiate review of a request for Utilization Review services to include the patient's name and your name (if different from patient's name), attending Physician's name, treatment facility's name, diagnosis, and date of service.

Ordering Provider

The Physician or other provider who specifically prescribes the health care service being reviewed.

Peer Clinical Review (er)

Clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal, the Peer Clinical Reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

Prospective Review

Utilization Review conducted prior to a patient's stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or precertification.

Retrospective Review

Utilization Review conducted after the patient is discharged from a Hospital or other health care facility or has completed a course of treatment.

Urgent Review

Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to your or the patient's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of your or the patient's medical condition, would subject your or the patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon Our determination using the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Utilization Review

A set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

Utilization Management Requirements - Applicable to medical care received from Non-Preferred Providers

Benefits payable for Hospital Inpatient Confinement Charges will be reduced by 25% unless:

- For Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested from Us by you, a Dependent, or a designated patient representative as soon as a Hospital Inpatient Confinement is scheduled, but no later than two business days before a Hospital Inpatient Confinement, for other than a Medical Emergency; and for a Medical Emergency, within two business days of a Hospital Inpatient Confinement or as soon as reasonably possible.

  If a Hospital Admission Review is not requested in a timely manner as specified above, the 25% reduction in benefits payable will be applied to all Hospital Inpatient Confinement Charges.

  Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges We determine to be a Covered Charge.

  Certain exceptions apply to Hospital Inpatient Confinement for childbirth and mastectomy and services incidental to a mastectomy as described below.

The 25% reduction in Benefits Payable is a penalty for failure to comply with the Utilization Management Requirements listed. The reduction:

- will not count toward satisfaction of the Out-of-Pocket Expense limits described in the Summary of Benefits section; and

- will not exceed $2,000 per individual each calendar year.

Hospital Admission Review - Applicable to medical care received from Non-Preferred Providers

A Hospital Admission Review by Us is required for all Hospital Inpatient Confinements (scheduled or emergency).

The following exception applies to Hospital Inpatient Confinement for childbirth:

Covered Charge requirements are waived and a Hospital Admission Review is not required for mother and baby, for:

- a 48-hour Hospital Inpatient Confinement following vaginal delivery; or
- a 96-hour Hospital Inpatient Confinement following cesarean section.

A request for review by Us of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by you, a Dependent, or a designated patient representative, before the end of that time period.

If you, a Dependent, or a designated patient representative fail to request a Hospital Admission Review as specified in this section, benefits will be reduced as described above.

Exception: For all Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth, the penalty will be applied beginning the day after the automatically approved time period ends. **Except as waived above, no benefits will be payable for any Treatment or Service that is not for a Covered Charge.**

For the purpose of these requirements, "Hospital Admission Review" means review by Us of a Physician's report of the need for a Hospital Inpatient Confinement, scheduled or emergency, (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).

The report (verbal or Written) must include the:

- reason(s) for the Hospital Inpatient Confinement; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the Hospital Inpatient Confinement.

If a Hospital Inpatient Confinement will exceed the approved number of days, We will initiate a Continued Stay Review. For the purpose of these requirements, "Continued Stay Review" means a review by Us of a Physician's report of the need for continued Hospital Inpatient Confinement.

The report (verbal or Written) must include the:

- reason(s) for requesting continued Hospital Inpatient Confinement; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the continued Hospital Inpatient Confinement.

Notice of Utilization Review

For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when We receive

Notification of Utilization Review Services. We may request additional information to substantiate loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with Our request could result in declination of Utilization Review services.

If you, your Dependent, or designated patient representative fails to follow Our procedures for filing a claim for a Hospital Admission Review, a Prospective Review, or an Urgent Review, We will notify you, your Dependent or designated patient representative of the failure and the proper procedures to be followed.

Utilization Review Program

- **Prospective Review**

  For an initial Prospective Review, a decision and notification of the decision will be made within 15 calendar days of the date We receive Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, We will either issue a Noncertification or send an explanation of the information needed to complete the review prior to expiration of the 15 calendar days. If We do not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. We will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, We will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient. Upon request, We will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient.

- **Urgent Prospective Review**

  For Urgent Review of a Prospective Review, a decision and notification of the decision will be made within 72 hours of the date We receive Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, We will either issue a Noncertification or send an explanation of the information needed to complete the review within 24 hours of receipt of Notification of Utilization Review Services. If We do not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 48 hours to provide the necessary information. We will render a decision within 48 hours of either receiving the necessary information or if no additional information is received, the expiration of the 48 hours to provide the specified additional information. For certifications, We will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient. Upon request, We will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient.

- **Concurrent Review**

  For a Concurrent Review that does not involve an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by Us will be decided within the timeframes and according to the requirements for Prospective Review.

  For an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by Us will be decided and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. If a request is made less than 24 hours prior to the expiration of the previously approved period or number of treatments, a decision and notification of the decision will be made within 72 hours of receipt of the Notification of Utilization Review Services.

- **Retrospective Review**

For a Retrospective Review, a decision and notification of the decision will be made within 30 calendar days after We receive Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, We will either issue a Noncertification or send an explanation of the information needed to complete the review prior to the expiration of the 30 calendar days. If We do not issue a Noncertification and requests additional information to complete the review, you, the patient, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. We will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, We will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient. Upon request, We will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient.

- **Request for Reconsideration**

When an initial decision is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one (1) business day to discuss the Noncertification decision with the attending Physician or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician or other Ordering Provider will be informed of their right to initiate an appeal and the procedure to do so. For certifications, We will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient. Upon request, We will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and you or the patient.

- **Appeal of Noncertifications**

You, your Dependent, a designated patient representative, Physician, or other health care provider has the right to request two appeal reviews of any utilization management decision by telephone, fax, or in Writing. We will make a full and fair review of the Noncertification. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

- **Expedited Appeal Review and Voluntary Appeal Review**

An Expedited Appeal Review is a request, usually by telephone but can be Written, for a review of a decision not to certify an Urgent Review. An Expedited Appeal Review must be requested within 180 calendar days of the receipt of a Noncertification.

A decision and notification of the decision on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review. Written or electronic notification of the appeal review outcome will be made to the attending Physician or other Ordering Provider and you or the patient.

If the Noncertification is affirmed on the appeal review, you, the patient, attending Physician, or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax or in Writing. You, the patient, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for appeal. We will make a decision within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for you or the patient's Signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to you within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30

calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate you or the patient's right to bring civil action following notification of the decision rendered during the expedited appeal, nor does it have any effect on you or the patient's rights to any other benefit under this Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies.

Note: The expedited appeal process does not apply to Retrospective Reviews.

Standard Appeal Review and Voluntary Appeal Review

A standard appeal may be requested either in Writing or verbally. It must be requested within 180 calendar days of the receipt of a Noncertification. A decision and notification of the decision will be made in Writing to you or the patient, the attending Physician or other Ordering Provider within 30 calendar days of receiving the request for an appeal.

If the Noncertification is affirmed on the appeal review, you, the patient, attending Physician, or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax or in Writing. You, the patient, attending Physician or other Ordering Provider may submit Written comments, documents, records, and other information relating to the request for appeal. We will make a decision within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for you or the patient's Signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to Us within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate you or the patient's right to bring civil action following notification of the decision rendered during the standard appeal, nor does it have any effect on you or the patient's rights to any other benefit under this Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies.

SEE THE CLAIMS PROCEDURES SECTION OF THIS BOOKLET FOR IMPORTANT CLAIM PROCEDURES INFORMATION ON FILING YOUR MEDICAL CLAIMS.

DESCRIPTION OF BENEFITS

PRESCRIPTION DRUGS EXPENSE INSURANCE

Payment Condition

Subject to the terms and limitations of the Group Policy summarized in this booklet, if drugs and medicines are prescribed to treat you or one of your Dependents, We will pay 100% of the charges in excess of the Copay amount as described in the Summary of Benefits Section.

Benefit payment will be limited to:

- Covered Charges as described in this section; and
- for certain qualified Maintenance Drugs and Medicines, a 90-day supply for each prescription and each refill; and
- for all other drugs and medicines, not more than a 30-day supply for each prescription and each refill; and
- prescriptions filled by a Member Pharmacy.

If you or a Dependent use a Nonmember Pharmacy, Prescription Drugs Covered Charges less the Copay may only be reimbursed up to the amount determined by the Payment Schedule established by Us for each prescription or refill.

Prescription Drugs Utilization Review Program

For Maintenance Drugs and Medicines

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same insured person) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

For all other Drugs and Medicines

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription or refill (for the same insured person) and the previously dispensed quantity of the drug or medicine was for:

- Less than a 15-day supply and the dispensing date for the current prescription is more than four days before a previously dispensed supply would be exhausted; or
- More than a 14-day supply and the dispensing date for the current prescription is more than ten days before the previously dispensed supply would be exhausted; or
- More than a 14-day supply and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

Exhaustion of the previously dispensed supply is determined based on when the last dose of the medicine or drug would have been consumed if the previously dispensed supply was consumed by the prescription date. Prescriptions may be refilled prior to exhaustion of a previously dispensed quantity for the same prescription or refill for up to a 30 day quantity once per calendar year.

For certain drugs or classes of drugs designated by Us, We reserve the right to:

- require prior authorization for dispensing; and
- limit payment of benefits for specified quantities; and
- require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by Us.

Prescription Drugs Covered Charges

Prescription Drugs Covered Charges will be the actual cost charged to you or your Dependent but only to the extent that the actual cost charged does not exceed the maximum amount allowed under the Payment Schedule as established by Us.

Prescription Drugs Covered Charges will include charges for:

- the following diabetic supplies:
  - insulin; and
  - disposable insulin needles/syringes; and
  - disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, and Clinitest tablets); and
  - lancets;
  - glucometers (limited to no more than one each calendar year); and
  - alcohol swabs; and
- compounded medications (except for compound medications that use an injectable drug) in which at least one ingredient is a Prescription Legend Drug. Reimbursement for compounded medications will be up to 135% of Average Wholesale Price of the most expensive active ingredient; and
- the following injectable medications; epinephrine, glucagons and triplans; and
- legend contraceptives except injectables or devices; and
- any other drug or medicine that can be legally dispensed only upon the Written prescription of a Physician.

In no event will the maximum amount allowed under the Payment Schedule for each prescription or refill exceed the Average Wholesale Price less 14%.

Definitions

"Average Wholesale Price" means the published cost of a drug product that is paid by the pharmacist to the wholesaler.

"Brand Name Prescription Drug/Brand Name Drug" means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

"Formulary" means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers.

"Generic Prescription Drugs" mean pharmaceutical products manufactured and sold under their chemical, common or official name or drug that We identify as a Generic Drug. Classification of a Prescription Drug as a Generic is determined by Us and not by the manufacturer or pharmacy. We classify a Prescription drug as a Generic based on available data resources, therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified as a Generic by Us.

"Maintenance Drugs and Medicines" mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina); diabetes (including, diabetic supplies, e.g., insulin, disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone

testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets; glucometers (limited to one each calendar year); and alcohol swabs); hypertension; glaucoma; thyroid disease; seizure disorders; hyperlipidemia; congestive heart failure; clotting disorders; chronic obstructive pulmonary disease; and hormonal deficiencies (hormone replacement); Attention-Deficit/Hyperactivity Disorder (ADHD); narcolepsy; arthritis; gout; Parkinson's disease; asthma; antineoplastics; immunosuppressives; and Human Immunodeficiency Virus (HIV), potassium supplements and pancreatic enzymes. Maintenance Drugs and Medicines will also include legend oral contraceptives.

"Member Pharmacy" means any pharmacy which has contracted with Pharmacy Benefit Manager to provide prescription drugs for which benefits are provided under the Group Policy.

"Nonmember Pharmacy" means any pharmacy which has not contracted with the designated prescription drugs claims administrator to become a Member Pharmacy.

"Payment Schedule" means the maximum reimbursement amount allowed under the program as established by Us.

"Pharmacy Benefit Manager" means CaremarkPCS.

"Prescription Drug Copay" means a specified dollar amount that must be paid by you or one of your Dependents for each prescription and each refill. The Prescription Drug Copay amount will not be applied to the Comprehensive Medical Deductible Amount or Out-of-Pocket Expense limits.

"Prescription Legend Drugs" mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

"Tier 1 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 2 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 3 Prescription Drugs" mean a list of prescription drugs established by The Principal.

Limitations

Prescription Drugs Covered Charges will not include and no benefits will be paid for:

- drugs or medicines that are not for Covered Charges; or
- drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or
- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or
- drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which you or a Dependent is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements; or
- contraceptives, non-oral dosage forms, excluding patches and vaginal rings; or

- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as specifically provided above under Prescription Drug Covered Charges; or

- infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or

- administration of any drug or medicine; or

- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or

- drugs or medicines for which you or a Dependent have no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or

- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless charges are imposed against the person for such drugs or medicines; or

- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or

- drugs or medicines provided as the result of a sickness or injury that is due to participation in criminal activities; or

- drugs or medicines covered by medical expense insurance issued under the Individual Purchase Rights described in this booklet; or

- drugs or medicines provided as the result of:

  - an injury arising out of or in the course of any employment for wage or profit if you or your Dependent are eligible to be covered under a Workers' Compensation Act or other similar law; except that this limitation will not apply to partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or

  - a sickness covered by a Workers' Compensation Act or other similar law; or

- growth hormones; or

- cosmetic, and health and beauty aids; or

- Levonorgestrel (Norplant); or

- dermatologicals used as hair growth stimulants; or any other drugs or medicines used for cosmetic purposes; or

- drugs labeled "Caution--limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or

- topical dental fluorides; or

- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or

- drugs or medicines that are lost, stolen or spilled; or

- smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms; or

- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or
- drugs or medicines prescribed or dispensed outside the United States, except those provided or dispensed in connection with a Medical Emergency; or
- hematinics; or
- drugs or medicines for the treatment of onychomycosis (nail fungus); or
- drugs or medicines that are paid for by a Medicare Supplement Insurance Plan; or
- drugs or medicines prescribed for treatment leading to, in connection with or resulting from sexual transformation or intersex surgery.

Payment, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on your or the Dependent's identification card or contact Us. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or Us within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or We receive proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or We may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the request of Pharmacy Benefit Manger or Us could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or We will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manger or We will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or We receive complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or We will submit a detailed explanation of the basis for its denial.

A Claimant may request an appeal of a claim denial by Written request to Us within 180 calendar days of receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in Writing. The claimant may submit Written comments, documents, records and other information relating to the claim for benefits. We will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for the claimant's Signature so information can be obtained from the provider. This information must be sent to Us within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information

to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefits under this Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "claimant" means you or the Dependent.

DESCRIPTION OF BENEFITS

MAIL SERVICES PRESCRIPTION DRUGS EXPENSE INSURANCE

Payment Conditions

Subject to the terms and limitations of the Group Policy summarized in this booklet, if Maintenance Drugs and Medicines are prescribed to treat you or one of your Dependents, We will pay 100% of charges in excess of the Copay amount as described in the Summary of Benefits Section.

Benefit payment will be limited to:

- prescribed maintenance medications which are necessary to treat a chronic or long-term sickness or injury and that can be legally dispensed only upon the Written prescription of a Physician; and
- a 90-day supply for each prescription and each refill; and
- prescriptions which are filled through the pharmacy designated by Us to administer the mail order prescription drugs program.

Prescription Drugs Utilization Review Program

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same insured person) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

For certain drugs or classes of drugs designated by Us, We reserve the right to:

- require prior authorization for dispensing; and
- limit payment of benefits for specified quantities; and
- require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by Us.

Definitions

"Brand Name Prescription Drug/Brand Name Drug" means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

"Formulary" means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers.

"Generic Prescription Drugs" mean pharmaceutical products manufactured and sold under their chemical, common or official name or a drug that We identify as a Generic Drug. Classification of a Prescription Drug as a Generic is determined by Us and not by the manufacture or pharmacy. We classify a Prescription Drug as a Generic based on available data resources, therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified as a Generic by Us.

"Maintenance Drugs and Medicines" mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina); diabetes (including, diabetic supplies, e.g., insulin, disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets; glucometers (limited to one each calendar year); and

alcohol swabs); hypertension; glaucoma; thyroid disease; seizure disorders; hyperlipidemia; congestive heart failure; clotting disorders; chronic obstructive pulmonary disease; and hormonal deficiencies (hormone replacement); Attention-Deficit/Hyperactivity Disorder (ADHD); narcolepsy; arthritis; gout; Parkinson's disease; asthma; antineoplastics; immunosuppressives; and Human Immunodeficiency Virus (HIV), potassium supplements and pancreatic enzymes. Maintenance Drugs and Medicines will also include legend oral contraceptives.

"Payment Schedule" means the maximum reimbursement amount allowed under the program as established by Us.

"Pharmacy Benefit Manager" means CaremarkPCS.

"Prescription Drug Copay" means a specified dollar amount that must be paid by you or one of your Dependents for each prescription and each refill. The Prescription Drug Copay amount will not be applied to the Comprehensive Medical Deductible Amount or Out-of-Pocket Expense limits.

"Prescription Legend Drugs" mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

"Tier 1 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 2 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 3 Prescription Drugs" mean a list of prescription drugs established by The Principal.

Mail Service Pharmacy

We have contracted with Caremark PCS, a mail service pharmacy to administer this program.

90-Day Supplies

Typically, prescriptions submitted to the Pharmacy will be filled in 90-day supplies. Please have your Physician contact the Pharmacy at the toll-free number shown on your order form if there are any questions.

How to Order From the Pharmacy

Your initial order consists of three parts: the Written prescription from your Physician; a Patient/Profile Order form with preaddressed envelope; and a Copay. These are described below. You should allow 14 days for your order to be completed and shipped to you. All orders are mailed either by Federal Express or First Class U.S. Mail. If you wish to have your order shipped Federal Express, you will need to pay the cost.

The Written Prescription

When obtaining your prescription, be sure to ask your Physician to specify the following information:

- patient name;
- prescription for a 90-day supply of medication (the Physician should indicate the total number of pills required for that period of time. For example, 270 tablets would be needed for medication that must be taken three times a day.);
- refills (many maintenance drugs can be prescribed for up to one year; therefore, a prescription for a 90-day supply may specify up to three refills.);
- Physician's signature.

Also it is very important to include your name, address, and social security number on the prescription form, so that eligibility for the program can be verified when the Pharmacy receives the order.

Patient Profile/Order Form

Included in the installation package you receive, as well as with each order shipped, is the Patient Profile/Order Form. This form is to be completed and sent in the preaddressed envelope with each order. The Patient Profile/Order Form provides information concerning eligibility in addition to health and allergy conditions pertaining to each covered person.

Copay

A check or money order for the correct Copay must accompany each order. The Copay amount is described in the Summary of Benefits Section. You may also be able to charge your Copay to a credit card as explained on the Patient Profile/Order Form. Please do not send cash.

Refills or Follow-up Orders

Each filled order you receive includes Refill Ordering Instructions, a Patient/Profile Order Form, and a preaddressed envelope. Orders for refills should be placed approximately 30 days before the current supply of medication is expected to run out.

Special Situations

If a maintenance medication is prescribed for immediate use, you should obtain two prescriptions--one for a 14-day supply to be filled immediately at a local Member Pharmacy, and a second for an extended 90-day supply with refills, to be filled by the mail service pharmacy.

Questions

If you have a question concerning medication or a particular order, you can call the pharmacy's customer service number. The toll-free number is shown on your order form.

Also included with each order filled is a Patient Counseling information sheet which has specific information about the medication included with the order.

Limitations

Prescription Drugs Covered Charges will not include and no benefits will be paid for:

- drugs or medicines that are not for Covered Charges; or
- drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or
- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or
- drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which you or a Dependent is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements; or

- contraceptives, non-oral dosage forms, excluding patches and vaginal rings; or
- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use; or
- infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or
- administration of any drug or medicine; or
- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or
- drugs or medicines for which you or a Dependent have no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless charges are imposed against the person for such drugs or medicines; or
- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or
- drugs or medicines provided as the result of a sickness or injury that is due to participation in criminal activities; or
- drugs or medicines covered by medical expense insurance issued under the Individual Purchase Rights described in this booklet; or
- drugs or medicines provided as the result of:
    - an injury arising out of or in the course of any employment for wage or profit if you or your Dependent are eligible to be covered under a Workers' Compensation Act or other similar law; except that this limitation will not apply to partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
    - a sickness covered by a Workers' Compensation Act or other similar law; or
- growth hormones; or
- cosmetic, and health and beauty aids; or
- Levonorgestrel (Norplant); or
- dermatologicals used as hair growth stimulants; or any other drugs or medicines used for cosmetic purposes; or
- drugs labeled "Caution--limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or
- topical dental fluorides; or
- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- drugs or medicines that are lost, stolen or spilled; or
- smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms; or

- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or
- drugs or medicines prescribed or dispensed outside the United States, except those provided or dispensed in connection with a Medical Emergency; or
- hematinics; or
- drugs or medicines for the treatment of onychomycosis (nail fungus); or
- drugs or medicines that are paid for by a Medicare Supplement Insurance Plan; or
- drugs or medicines prescribed for treatment leading to, in connection with or resulting from sexual transformation or intersex surgery.

Group Medical Drug Insurance

Insurance for prescribed drugs and medications will continue to be available under the Comprehensive Medical Expense Insurance and under the regular prescription drug program. Under the Comprehensive Medical Expense Insurance, a calendar year Deductible must first be satisfied and then benefits will be payable as described in the Summary of Benefits section.

Payment, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on your or the Dependent's identification card or contact Us. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or Us within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or We receive proof of loss. Proof of loss includes the patient's name, your name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or We may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the request of Pharmacy Benefit Manger or Us could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or We will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manger or We will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or We receive complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or We will submit a detailed explanation of the basis for its denial.

A Claimant may request an appeal of a claim denial by Written request to Us within 180 calendar days of receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in Writing. The claimant may submit Written comments, documents, records and other information relating to the claim for

benefits. We will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for the claimant's Signature so information can be obtained from the provider. This information must be sent to Us within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefits under this Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "claimant" means you or the Dependent.

MEDICAL EXPENSE INSURANCE

PREEXISTING CONDITION EXCLUSION

The Preexisting Condition Exclusion provisions described in this section will apply only to:

- individuals whose coverage becomes effective under the Group Policy on its Date of Issue; and
- individuals who are Late Enrollees as defined in GH 115 A (MED).

Definition

A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of an individual's coverage under the Group Policy.

However, pregnancy will not be considered a Preexisting Condition.

Genetic information will not be considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information.

Exclusion Period

Benefits for Treatment or Service of an individual's Preexisting Condition will be excluded for a period of 12 consecutive months after the effective date of the individual's coverage under the Group Policy; and then benefits will be payable only with respect to Treatment or Service received after the exclusion period.

Exemption for Certain Dependent Children. The Preexisting Condition Exclusion described above, will not apply to any Dependent Child:

- who is the Member's newborn child, or a child newly adopted by the Member (or Placed for Adoption with the Member) prior to the child's attainment of age 18; and
- whose coverage becomes effective under the Group Policy within the 31-day period immediately following the date of birth, adoption or Placement for Adoption.

If a Dependent Child becomes covered under the Group Policy other than as described above, that child will also be exempt from the Preexisting Condition Exclusion if:

- the child was covered under another Creditable Coverage as of the last day of the 31-day period beginning with the child's date of birth, adoption or Placement for Adoption (provided the adoption or Placement occurred prior to the child's attainment of age 18); and
- the child has subsequently maintained continuous Creditable Coverage, with no gap in coverage exceeding 63 days.

If any such child's coverage under the Group Policy terminates and the child later becomes covered again under the Group Policy, the exemption will continue to apply to the child unless there has been a period of at least 63 days during all of which the child was not covered under any Creditable Coverage.

For the purpose of these provisions, a Waiting Period or HMO Affiliation Period will not be considered a break in Creditable Coverage.

Credit for Previous Creditable Coverage

The Preexisting Condition exclusion period will be reduced by days of continuous Creditable Coverage, if any, applicable to the individual as of the effective date of his or her coverage under the Group Policy.

In determining days of continuous Creditable Coverage, any period of Creditable Coverage which occurs before a significant break in coverage will not be counted. For this purpose, "significant break in coverage" means a period of 63 days during all of which a person is not covered under any Creditable Coverage. However, a Waiting Period or an HMO Affiliation Period will not be considered a break in coverage.

With respect to an individual becoming covered under the Group Policy, a period of Creditable Coverage will not be considered continuous if, after such period and before the effective date of the individual's coverage, there was a 63-day period during all of which the individual was not covered under any Creditable Coverage.

MEDICAL EXPENSE INSURANCE

EXTENDED BENEFITS (after termination of insurance)

If Medical Expense Insurance under the Group Policy ceases and if you or your Dependents qualifies, We will pay Comprehensive Medical benefits for Treatment or Service received after termination of insurance to the extent that these benefits would have been paid had insurance remained in force.

You or your Dependent will qualify if Hospital Inpatient Confined from the date insurance ceases to the date of Treatment or Service.

However, extended benefits will be payable only for Treatment or Service received for the condition that caused the Hospital Inpatient Confinement and which was diagnosed by a Physician before the date insurance terminated.

Extended benefits are payable if insurance ceases due to termination of the Group Policy. Extended benefits will be payable for up to 12 months, provided:

- you or your Dependent have been Totally Disabled from the date insurance ceased until the date of the Treatment or Service; and
- you or your Dependent would have qualified for benefit payment under this section if insurance had remained in force; and
- the sickness or injury for which you or your Dependent receives Treatment or Service is the disabling condition and was diagnosed by a Physician before the date insurance terminated.

These extended benefits are payable whether or not the Group Policy is replaced. However, if the Group Policy is replaced, the extended benefits will cease on the earlier of:

- the date 12 months after the date insurance terminates; or
- the date the succeeding carrier provides replacement coverage to you or your Dependents without limitation as to the disabling condition.

MEDICAL EXPENSE INSURANCE

INDIVIDUAL PURCHASE RIGHTS

If your Medical Expense Insurance terminates and you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaces) for at least the 3-month period immediately prior to the date insurance terminates, you may buy other medical expense insurance from Us. Except that, you may not buy other medical expense insurance if your Medical Expense Insurance terminates because:

- you fail to pay any required contribution; or
- you reach the Comprehensive Medical Overall Lifetime Maximum Payment Limit; or
- the Group Policy terminates and continuous coverage is provided under a replacement group medical expense coverage.

A statement of health will not be required. The other coverage will be on one of the forms We then issue to persons who apply for individual purchase.

NOTE: The benefits provided under the conversion policy are not the same as the benefits provided under the Group Policy. Specific details regarding the terms of the conversion policy may be obtained from Us or from your employer.

The persons to be covered under the other medical expense insurance will be you and all of your Dependents who are covered under the Group Policy on the date insurance ceases, except that any Developmentally Disabled or Physically Handicapped child beyond the maximum age for Dependent Children will be covered as provided in the last paragraph.

We will not issue other medical expense insurance if you are covered by similar coverage which, together with this coverage, may result in overinsurance based on Our standards for overinsurance.

You must apply for individual purchase and pay the first premium to Us within 31 days after your insurance under the Group Policy is terminated. The premium you pay will be at Our normal rate for your age and for the risk class to which you belong. See the Policyholder for the proper forms. The other medical expense insurance will then be in force on the day after that termination date.

Your spouse may buy other medical expense insurance in the same manner as described above for you, if insurance under the Group Policy ceases for your spouse because:

- of your death; or
- of divorce or legal separation.

A Dependent Child may also buy other medical expense insurance in the same manner as described above for you, if insurance under the Group Policy ceases for the Dependent Child because the child is no longer eligible as a Dependent.

A Dependent Child beyond the maximum age for Dependent Children, who is incapable of self-support because of a Developmental Disability or Physical Handicap may also buy other medical expense insurance in the same manner as described above for you, if the Dependent Child's insurance under the Group Policy ceases because your insurance terminates as described above.

NOTE: Individual Purchase is also available at the end of any continuation period, provided the person is not then covered for similar coverage which, together with this coverage, would result in overinsurance based on Our standards for overinsurance.

MEDICAL EXPENSE INSURANCE

COORDINATION WITH OTHER BENEFITS

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan when you or one of your Dependents have health care insurance under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- Will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under the Group Policy will not exceed the lesser of the financial liability of the Member or Dependent or the Prevailing Charge of The Principal for a Treatment or Service.

Definitions

"Plan" is any of these which provides benefits or services for, or because of, medical care or treatment.

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
- any program required or established by state or Federal law (including Medicare Parts A, B, C and D); and
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts, including the self-insured equivalent of any minimum benefits required by law.

The term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

Primary Plan/Secondary Plan: The order of benefit determination rules determine whether this Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

Allowable Expense: A health care service or expense, including Deductibles, coinsurance, and Copayments, if any, that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of Generally Accepted medical practice, or one of the Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

- The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.

"Claim Determination Period" means the part of a calendar year during which you or a Dependent would receive benefit payments under This Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of This Plan.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;
- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, C and D whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- Non-Dependent/Dependent. The plan which covers the person as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - Secondary to the Plan covering the person as a Dependent; and
  - Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee),

  then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.
- Dependent Child--Parents Not Separated or Divorced. If a child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- **Dependent Child–Separated or Divorced Parents.** If a child of legally separated or divorced parents is covered under two or more Plans, benefits for the child are determined in this order:
  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Continuation of Coverage.** If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:
  - first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
  - second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active (rather than a retired) Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

How COB Works

Example 1: The natural father is insured as a Member under This Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the child and the divorce decree does not establish financial responsibility for medical, dental, or other health care expenses.

The following order of benefits would apply to the child:

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. We would then determine the benefits payable, if any, under This Plan.

Example 2A: Mrs. Smith has filed a claim for $2,400 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a $200 calendar year deductible is satisfied. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

Company A

Billed Charges	$ 2,400
Not Covered By Primary Carrier	200 (Personal Items)
Total Covered Charges	$ 2,200
Other Carriers Deductible	200
Benefits Payable ($2,000 X 80% = $1,600)	$ 1,600

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$ 2,200
Less Company A Benefits	1,600
Benefits Payable	$ 600

The Patient is responsible for $200 which is not considered a covered expense under either policy.

Example 2B: The same rules apply in this example as they did in Example 2A. Mrs. Smith has filed an additional claim for $5,000 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a $200 calendar deductible is satisfied. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since

Company A pays first, it calculates benefits according to their plans Covered Charges as though duplicate coverage did not exist.

Company A

Billed Charges	$ 5,000
Not Covered By Primary Carrier	500 (Private Room)
Total Covered Charges	$ 4,500
Other Carriers Deductible	200
Benefits Payable ($4,300 X 80% = $3,440)	$ 3,440

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$ 4,500
Less Company A Benefits	3,400
Benefits Payable By Company B	$ 1,060

The Patient is responsible for $500 which is not considered a covered expense under either policy.

MEDICAL EXPENSE INSURANCE

SUBROGATION AND REIMBURSEMENT

Applicability

Subject to applicable law, this section will apply to Members and Dependents who:

- receive benefit payment under the Group Policy as a result of a sickness or injury; and
- have a lawful claim against another party, parties, or insurer (including uninsured, underinsured, and no-fault automobile insurers) for compensation, damages, or other payment because of that same sickness or injury.

We will have the right of first reimbursement from any recovery a Member or Dependent receives even if the Member or Dependent has not been made whole.

Transfer of Rights

In those instances where this section applies, the rights of the Member and/or Dependents to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to Us, but only to the extent of benefit payments made under the Group Policy.

Member and Dependent Obligations

To secure Our rights under this section, a Member and/or Dependents must:

- Complete any applications or other instruments and provide any documents We might require, and cooperate with Us and Our agents in order to protect Our subrogation rights.
- If payment from the other party or parties has been received, reimburse Us for benefit payment made under the Group Policy (but not more than the amount paid by the other party or parties.)
- The Member and/or Dependent will not take any action that prejudices Our rights. If the Member or Dependent enters into litigation or settlement negotiations regarding the obligations of other parties, the Member and/or Dependent must not prejudice, in any way, Our subrogation rights under this Section.

The costs of legal representation retained by Us in matters related to subrogation will be borne solely by Us. The costs of legal representation retained by the Member and/or Dependent will be borne solely by the Member or Dependent.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Except in the case of medical care received from Preferred Providers, claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 calendar days after We receive such notice of claim, you will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when We receive proof of loss. Proof of loss includes the patient's name, your name (if different from patient's name) provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. We may request additional information to substantiate your loss or require a Signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Payment, Denial, and Review

The Employment Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will either deny the claim or send a Written explanation requesting information prior to the expiration of the 30 calendar days. If We do not deny the claim and request additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. We will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits will be payable sooner, provided We receive complete and proper proof of loss. If a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for the denial.

A claimant may request an appeal of a claim denial by Written request to Us within 180 calendar days of receipt of the notice of denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in Writing. The claimant may submit Written comments, documents, records and other information relating to the claim for benefits. We will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, We will send a Written explanation of the additional information that is required or an authorization for the claimant's Signature so information can be obtained from the provider. This information must be sent to Us within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first

appeal, nor does it have any effect on the claimant's right to any other benefit under the Group Policy. We offer the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

For purpose of this section, "claimant" means Member or Dependent.

Medical Examinations

We may have the person whose loss is the basis for claim examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action with respect to a claim may not be started earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

Recoding of Procedures

When a claim contains one or more procedure codes with the same date of service, We may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. We will base such review on generally recognized and authoritative coding resources, including but not limited to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding Systems (HCPCS).

If We determine, in its own discretion, that the claim may be more appropriately codes using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

For Medical Insurance

Preferred Providers

When you become insured, you will be issued an identification card. This card should be presented to each Preferred Provider at the time you or a Dependent receive needed medical care. We will assist you with the Hospital Admission Review requirements.

Benefit Advice

Benefit Advice is Our toll-free service that can answer questions about your benefit program or specific coverages. The staff provides information on topics such as outpatient surgery, generic drugs, health care alternatives, health care providers, and treatment costs in your area.

The staff does not prescribe medical treatment. That is up to your Physician. But they can help you understand your benefits and how to use them in the most cost-effective manner.

Call Our toll-free Health Info Line number (see your ID card or your employer for the Health Info Line number) if you wish to discuss medical benefits with Our Benefit Advice staff. The number is also listed on page GH 103 in this booklet.

Hospital Admission Review - Applies only to Medical Care received from Non-PPO Providers

If a Hospital Inpatient Confinement is necessary, you will need to follow the procedures below in order to qualify for payment of Hospital Inpatient Confinement Charges at the standard rate for your plan. The procedures differ depending on the type of Hospital Inpatient Confinement:

- **For Other than a Medical Emergency**

  You, your Dependent, or a designated patient representative must call Us at the toll-free number as soon as Hospital Inpatient Confinement is scheduled, but no later than two business days before a Hospital Inpatient Confinement.

- **For a Medical Emergency**

  You, your Dependent, or a designated patient representative must call Us at the toll free number within two business days of a Hospital Inpatient Confinement.

- **For a Continued Stay Review**

  If the Hospital Inpatient Confinement will exceed the approved number of days, We will initiate a Continued Stay Review.

- **For Childbirth**

  A Hospital Admission Review is not required for mother and baby for 48 hours following a vaginal delivery or 96 hours following cesarean section.

  You, your Dependent, or a designated patient representative must call Us at the toll-free number before the end of the automatically approved time period if the mother or baby will remain Hospital Inpatient Confined beyond that time period.

  Notification of the number of approval days will be sent to you, your Physician, and the Hospital.

Facility of Payment For Medical Insurance

We will normally pay all benefits to you. However, if the claimed benefits result from a Dependent's sickness or injury, We may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at Our option, be paid to your estate, spouse, child, parent, or provider of medical services.
- If We believe a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, We may pay whoever has assumed the care and support of the person.
- Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of you or a Dependent.
- Benefits payable to LabOne facility will be paid directly to the facility.
- Benefits payable to Transplant Network Providers will be paid directly to the Transplant Network Provider.

STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. See GH 451, if applicable, for further information concerning preexisting condition exclusions.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Several words and phrases used to describe your coverage are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Alcohol or Drug Abuse Treatment Services means Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including, but not limited to: individual, family or group psychotherapy; psychiatric diagnostic interviews or examinations; behavior modification; alcohol or drug abuse medication management; alcohol or drug abuse rehabilitation or counseling services; biofeedback, or milieu or other therapies (physical, occupational or speech therapy), used to diagnose or treat alcohol or drug abuse problems.

Ambulatory Surgery Center means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority in the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and
- does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

Average Wholesale Price means the published cost of a drug product to the wholesaler.

Birthing Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a Written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

Community Mental Health Center means a community or county mental health facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient Mental Health or Behavioral Treatment Services.

Copayment; Copay means a specified dollar amount that must be paid by you or a Dependent each time certain or specified services are rendered. In no event will the Copay amount exceed:

- for services provided by PPO Providers, the negotiated fee; and
- for services provided by Non-PPO Providers, the actual cost charged to you or your Dependent.

Cosmetic Treatment and Services means Treatment or Services to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such Treatment or Service is performed primarily for psychological purposes or is not needed to correct or improve a bodily function. Cosmetic Treatment and Services include, but are not limited to surgery, pharmacological regimens, and all related charges.

Covered Charges means a Treatment or Service is considered to be a Covered Charge if the Treatment or Service is:

- prescribed by a Physician and required for the screening, diagnosis or treatment of a medical conditions;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by The Principal to be Generally Accepted.

Creditable Coverage means with respect to an individual, coverage of the individual under any of the following:

- a Group Health Plan, as defined in this section;
- Health Insurance Coverage, as defined in this section;
- Medicare (Part A or Part B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);
- TRICARE (Chapter 55 of Title 10, United States Code);
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health benefit plan for government employees (Chapter 89 of Title 5, United States Code);
- a public health plan;
- a health benefit plan provided under the Peace Corp Act;
- any other similar coverage permitted under state or federal law or regulations.

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits. For this purpose, "Excepted Benefits" means benefits or coverage under one or more (or any combination) of the following:

- coverage only for accident (including accidental death and dismemberment);
- disability income insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- coverage issued as a supplement to liability insurance;

- Workers' Compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance (for example, mortgage insurance);
- coverage for on-site medical clinics;
- other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;
- the following benefits if offered separately from medical expense benefits (provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the plan):
  - limited scope dental or vision benefits;
  - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
  - other similar limited benefits;
- the following benefits if offered as independent, noncoordinated benefits:
  - coverage only for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance;
- the following benefits if offered as a separate insurance policy:
  - Medicare Supplement insurance;
  - coverage supplemental to TRICARE;
  - similar supplemental coverage provided to coverage under a Group Health Plan.

Custodial Care means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), chiropractor, physical therapist, occupational therapist, speech therapist or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination and taking medications.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by the insured person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the calendar year.

Dental Services mean any Treatment or Service provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or
- malocclusion (abnormal positioning or relationship of the teeth); or
- ailments or defects of the teeth and supporting tissue and bone (excluding appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

Dependent means:

- Your spouse, if your spouse:

- is not in the Armed Forces of any country; and
- is not insured under the Group Policy as a Member.

- Your Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children means:

- Your natural or legally adopted child, if that child:

  - is not married; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is less than 19 years of age.

  A newly adopted child will be considered a Dependent Child from the date of Placement with you for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- Your stepchild, if that child:

  - meets the requirements above; and
  - receives principal support from you.

- Your foster child, if that child:

  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is approved in Writing by Us as a Dependent Child.

- Your Dependent Child 19 years but less than 25 years of age who otherwise qualifies above, if that Dependent Child receives principal support from you and is a Full-Time Student, as defined.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

- is diagnosed by a Physician as a permanent or long-term continuing condition.

Experimental or Investigational Measures mean any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

Full-Time Employee means any PERSON INSIDE PPO SERVICE AREA who is regularly scheduled to work for the Policyholder for at least 30 hours a week. The employee must be compensated by the Policyholder and either the employee or the employer must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor or partner of the Policyholder's business will be deemed to be an employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student means your Dependent Child attending a school that has a regular teaching staff, curriculum and student

body and who:

- attends school on a full-time basis, as determined by the school's criteria; and
- is dependent on you for principal support.

Generally Accepted means Treatment or Service for the particular sickness or injury which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant medical community; and
- is not under scientific testing or research.

Group Health Plan means an employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance reimbursement, or otherwise.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members and Dependents.

Health Care Extender means a health care provider who assists in the delivery of covered medical services under the direction and supervision of a Physician.

"Direction and supervision" means the Physician co-signs any progress notes Written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

Health Insurance Coverage means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or Health Maintenance Organization (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO) licensed to engage in the business of insurance and subject to state law which regulates insurance.

Health Maintenance Organization (HMO) means an entity that is:

- A federally qualified Health Maintenance Organization as defined by federal law; or
- An organization recognized under state law as a Health Maintenance Organization; or
- A similar organization regulated under state law for solvency in the same manner and to the same extent as such a Health Maintenance Organization.

HMO Affiliation Period means a period of time which, under the terms of the Health Insurance Coverage offered by a Health Maintenance Organization (HMO), must expire before an individual's coverage becomes effective.

Home Health Aide means a person, other than a licensed registered nurse (R.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

Home Health Care Plan means a program of home care that:

- is required as the result of a sickness or injury; and
- prevents, delays or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and

- is documented in a Written plan of care; and
- is prescribed by the attending Physician; and
- is preapproved by Us.

Home Infusion Therapy Services mean Treatment or Service required for the administration of intravenous drugs or solutions, which:

- is required as a result of a sickness or injury; and
- prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician; and
- is preapproved by Us.

Hospice means a facility, agency, or service that:

- is licensed by the proper authority in the state in which it is located to establish and manage Hospice Care Programs; and
- arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Program means a program that furnishes palliative or supportive care focused on comfort and not cure and that is:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

Hospice Care Team means a group that provides coordinated Hospice Care Services and normally includes:

- a Physician;
- a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest

home, home for the aged, nursing home, custodial care facility, or training center.

For the purpose of Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services, the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

- a Psychiatric Hospital; and
- an Inpatient Alcohol or Drug Abuse Treatment Facility; and
- any other facility required by state law to be recognized as a treatment facility under the Group Policy.

Hospital Inpatient Confined; Hospital Inpatient Confinement means any period of Treatment or Service in a Hospital in excess of 23 consecutive hours for any cause. A Hospital Admission Review is required for all Hospital Inpatient Confinements.

Hospital Inpatient Confinement Charges mean Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia provided while a person is Hospital Inpatient Confined.

Hospital Room Maximum means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate if the Hospital has semiprivate rooms: or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Immediate Family means an insured person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Inpatient Alcohol or Drug Abuse Treatment Facility means an institution that is licensed by the proper authority of the state in which it is located and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services and;

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and
- provides 24-hour a day on-site nursing care by licensed registered nurses (R.N.s)

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; or
- serious impairment of bodily functions; or
- serious dysfunctions of a bodily organ or part.

Medically Necessary Care means any Treatment or Service that is prescribed by a Physician and considered to be necessary and appropriate and not in conflict with Generally Accepted medical standards.

Member means any person who is a Full-Time Employee of the Policyholder.

Mental Health or Behavioral Treatment Services means Treatment or Service provided to alter a person's behavior,

regardless of the cause of that behavior, including, but not limited to; individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric medication management; hypnotherapy; narcosynthesis; biofeedback, or milieu or other therapies (physical, occupational or speech therapy) used to diagnose or treat mental health or behavioral problems.

Non-Preferred Provider/Non-PPO Provider means a Hospital, Physician, or other provider not contracted with the Preferred Provider Organization (PPO) network established by the PPO identified on your ID card.

Outpatient Alcohol or Drug Abuse Treatment Facility means a facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.

Period of Confinement means a period of Hospital Inpatient Confinement. For the purposes of applying the Hospital charges Copay amount for each admission, two or more periods of Hospital Inpatient Confinement will be considered one period of confinement unless caused by an unrelated sickness or injury, or unless separated by 30 consecutive days or more.

Physical Handicap means a Dependent Child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); and
- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: audiologist, chiropractor, dentist, occupational therapist, optometrist, physician's assistant, physical therapist, podiatrist, psychologist, social worker, and speech pathologist.

Physician Visit means a face-to-face meeting between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service.

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policyholder means SOUMA DIAGNOSTIC LTD.

Preferred Provider/PPO Provider means a Hospital, Physician, or other provider contracted with the Preferred Provider Organization (PPO) network established by the PPO identified on your ID card.

The Policyholder's participation in the PPO network does not mean that an insured person's choice of provider will be restricted. The insured person may seek needed medical care from any Hospital, Physician, or other provider of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of the Group Policy if We or the PPO terminates the arrangement.

We also have the right to identify different Preferred Provider Organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

Preferred Provider Organization (PPO) means the PPO identified on your ID card.

Preferred Provider Organization (PPO) Service Area means the geographic area within which Preferred Provider services are available to persons insured under the Group Policy.

Prevailing Charges mean:

- For medical care received from Preferred Providers, the negotiated fee between the Provider and the PPO; and
- For medical care received from Non-Preferred Providers, the amount as determined by The Principal that is derived from a cost-based methodology used by Medicare or a methodology similar to one used by Medicare.
- For Home Infusion Therapy Services, the amount will be established by Us at the time services are preapproved, not to exceed the Average Wholesale Price.
- For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.
- For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.
- For purposes of Treatment or Service for a Medical Emergency provided outside the United States, the Prevailing Charge will be calculated based on the Policyholder's United States Address.

Primary Care Physician means a Physician who is a family or general practitioner, internist, obstetrician/gynecologist or pediatrician.

Psychiatric Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, and is primarily engaged in providing diagnostic and therapeutic Mental Health or Behavioral Treatment Services.

For the purpose of this definition, a Psychiatric Hospital will also include any inpatient bed in a licensed general Hospital used to provide diagnostic and therapeutic Mental Health or Behavioral Treatment Services in the absence of a specialized or designated psychiatric treatment unit.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by The Principal.

Skilled Nursing Facility means an institution (including one providing sub-acute care), or a distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places which furnish Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services.

Social Detoxification means Treatment or Service designed to achieve detoxification without the use of drugs or other medical interventions.

Specialty Provider means any Physician other than a Primary Care Physician who is classified as a specialist by the

American Boards of Medical Specialties; or who is designated by this Group Policy as a Specialty Provider.

Total Disability; Totally Disabled means:

- For a Member, a Member's inability, as determined by Us, due to sickness or injury, to work at any job that reasonably fits his or her background or training; and
- For a Dependent, a substantial impairment, due to sickness or injury, that prevents the individual from performing the normal function of his or her regular duties or activities.

Transplant Network means any network of providers We determine to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule as shown in this booklet. The Transplant Network is United Resource Networks.

Treatment or Service, when used in this booklet, means "confinement, treatment, service, substance, material or device".

Waiting Period means, with respect to a Group Health Plan and an individual who is a potential enrollee in the plan, the period of time that must pass with respect to the individual before he or she is eligible to be covered for benefits under the terms of the plan.

The Waiting Period for your coverage and the coverage of your eligible Dependents under the Group Policy is one month of continuous employment as a Member, as described in GH 115 A (MED).

We, Us, and Our mean Principal Life Insurance Company, Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

ILLINOIS NOTICE

This is to advise you that if you have any complaints about your insurance you may contact the following:

Principal Life Insurance Company
Attention: Government Relations
711 High Street
Des Moines, Iowa 50392-0220
Telephone: 1-800-325-2532

or

Illinois Department of Insurance
Consumer Division or
Public Services Section
320 West Washington Street
Springfield, Illinois 62767

Please identify all correspondence with the group account number and your full name and address. Please be as specific as possible about the nature of your complaint. Include all relevant information so that prompt action can be taken to resolve your complaint satisfactorily.

Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the practices of Principal Life Insurance Company for safeguarding individually identifiable personal health information. The terms of this Notice apply to members and dependents for their group medical expense, group dental expense and/or group vision care expense insurance. This Notice was effective April 14, 2003 and revisions to this Notice are effective June 1, 2005.

We are required by law to maintain the privacy of our members' and dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be mailed to plan sponsors for distribution to the members then covered by the plan. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

Uses and Disclosures of Your Personal Health Information

Authorization. Except as explained below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0302. A form to revoke an authorization can be obtained from the Health Information Protection Analyst.

Disclosures for Treatment. We may disclose your personal health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your personal health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your personal health information as necessary for payment purposes. For instance, we may use your personal health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also forward information to another insurer in order for it to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary for health care operations. For instance, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your personal health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with your health plan. Your health plan may have its own privacy practices that are not reflected in this Notice. We may disclose your personal health information to your health plan for its health care operations. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment. We may request and receive from you and your health care providers personal health information prior to your enrollment under the group policy. We will use this information to determine whether you are eligible to enroll under the policy and to determine the rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy laws.

Business Associate. Certain aspects and components of our services are performed by outside people or organizations

pursuant to agreements or contracts. It may be necessary for us to disclose your personal health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information.

Plan Sponsor. We may disclose your personal health information to the plan sponsor, provided that the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your personal health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Your Rights

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on how we use or disclose your personal health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Health Information Protection Analyst, Group Compliance,

Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request a restriction can be obtained from the Health Information Protection Analyst. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Personal Health Information. You have the right to request communications regarding your personal health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request a confidential communication can be obtained from the Health Information Protection Analyst.

Access to Your Personal Health Information. You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated record set, with a couple of exceptions. To request access to your information, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request access to your personal health information can be obtained from the Health Information Protection Analyst. A fee will be charged for copying and postage.

Amendment of Your Personal Health Information. You have the right to request an amendment to your personal health information to correct inaccuracies. To request an amendment, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request an amendment to your personal health information can be obtained from the Health Information Protection Analyst. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your personal health information. To request an accounting, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302. A form to request an accounting of your personal health information can be obtained from the Health Information Protection Analyst. The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0302 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Group Call Center at Principal Life Insurance Company at (800) 986-3343, extension 76398.

08CV4728
JUDGE GUZMAN
MAGISTRATE JUDGE SCHENKIER

PH

CYBERDRIVEILLINOIS

JESSE WHITE
SECRETARY OF STATE

CORPORATION FILE DETAIL REPORT

Entity Name	SOUMA DIAGNOSTICS LTD.	File Number	57095733
Status	GOODSTANDING		
Entity Type	CORPORATION	Type of Corp	DOMESTIC BCA
Incorporation Date (Domestic)	12/08/1992	State	ILLINOIS
Agent Name	ARTHUR S WULF	Agent Change Date	02/24/2004
Agent Street Address	77 W WASHINGTON #1910	President Name & Address	RUDY E SABBAGHA 351 WALLACE ROAD LAKE FOREST 60045
Agent City	CHICAGO	Secretary Name & Address	RUDY E SABBAGHA 351 WALLACE ROAD LAKE FOREST 60045
Agent Zip	60602	Duration Date	PERPETUAL
Annual Report Filing Date	11/26/2007	For Year	2007
Old Corp Name	03/11/1993 - SOUMA ENTERPRISES, LTD.		

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Purchase Certificate of Good Standing

(One Certificate per Transaction)

BACK TO CYBERDRIVEILLINOIS.COM HOME PAGE